S. HRG. 103–953

HEALTH CARE PREMIUMS AND SUBSIDIES

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MARCH 15 AND 17, 1994

Printed for the use of the Committee on Finance

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HEALTH CARE PREMIUMS AND SUBSIDIES

TUESDAY, MARCH 15, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:26 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Bradley, Daschle, Breaux, Conrad, Packwood, Dole, Roth, Chafee, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Releases No. H–17 and 18, March 11, 1994]

FINANCE COMMITTEE SETS HEARINGS ON HEALTH PREMIUMS AND SUBSIDIES

WASHINGTON, DC—Senator Daniel Patrick Moynihan (D-NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with hearings on health care premiums and subsidies in reform proposals before Congress.

The hearings will begin at *10:00 A.M. on Tuesday, March 15, 1994* in room SD–215 of the Dirksen Senate Office Building and at *10:00 A.M. on Thursday, March 17, 1994* in the same location.

"The Committee will examine ways that major reform proposals before the Congress attempt to achieve universal coverage with and without mandates," Senator Moynihan said in announcing the hearing. "We will be particularly interested in the structure of premiums and subsidies that are needed to implement various options."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning once again. As I explained, the Senate day began with a cloture vote which is always time consuming and usually unavailing. You do not happen to know how the vote was going when you left?

Senator PACKWOOD. It looked to me like the cloture was going to fail.

The CHAIRMAN. Unavailing. There you see, there is some constance observed in our activities.

We have a panel of most distinguished witnesses this morning, some of whom we have heard before, all of whom we have had a chance to talk to privately. The subject is health care premiums and subsidies. As the New York Times/CBS poll described in some length this morning, those two issues are the focus of the public's concern.

So I am looking forward to hearing from each of you in turn.

Senator Packwood?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. It is good to see these witnesses. We have seen Michael Graetz here many times in the past. It is good to have you back. I know Dr. Enthoven has been here before.

Despite the title, we are clearly talking today about mandates and whether or not we want mandates, among other things; and if we want universal coverage, can we get there without mandates, either an employer mandate similar to what we have in our employer/employee system or an individual mandate not unlike Germany or perhaps the State automobile insurance where we say to people you must have it?

And if you answer the question, yes, we want universal coverage, is there a way to get there without mandates? Is there a way to get the 22-year-old immortal motorcycle rider without a mandate to get health coverage if he does not have to get health coverage; or maybe we do not want universal coverage.

I would like to get universal coverage and I can accept a mandate, if necessary, to get there. But my mind is open if we can get there another way. It is interesting that of the bills before us, that President Clinton's has, of course, an employer mandate. Both Senator Chafee and Senator Nickles have individual mandates, not as tightly enforceable as I think you would want to get universal coverage, but they both have individual mandates. Then we have the issue of who is going to pay how much.

I think there is a general agreement that the President's 80/20 split between employers and individuals is too disproportionate on employers. And you have the issue, what do you do about small business that thinks it cannot afford any significant health insurance. Do we give them tax credits? Do we give them a 5-year, 10-year phase-in? If we do either, do we put off universal coverage too far if we give them credits? Do we have the money to pay for it?

So as usual, Mr. Chairman, I say this each time, this is one of the most important topics we have. This is one of the most important topics. Every one that we have fits into that category.

The CHAIRMAN. We are running a natural experiment on the immortal 22-year-old motorcyclist in our chief of staff, who has recently been married. [Laughter.]

Senator PACKWOOD. Does he have health insurance?

The CHAIRMAN. We will check him out in 3 months.

Senator Durenberger?

Senator DURENBERGER. I welcome the opportunity to be here.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. No, nothing. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Well, then we will get right to it. Stuart Butler, good morning, sir.

STATEMENT OF STUART M. BUTLER, PH.D., VICE-PRESIDENT AND DIRECTOR OF DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION, WASHINGTON, DC

Dr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify on the subject of securing universal coverage against the potentially devastating costs of medical care.

In my testimony I compare two possible ways of achieving this goal. One is an employer mandate, specifically the Clinton Administration's Health Security Act; the other is a system based on individual tax credits. Here I focus on a consumer choice legislation introduced by Senator Nickles with 24 additional Senate cosponsors.

My comments are based on a new study of these two bills, undertaken for the Heritage Foundation by Lewin-VHI. Let me begin by noting that an employer mandate is really a disguised mandate on employees, because an employer mandate simply means that employers are required to earmark part of a worker's compensation to buy health care. So there is no free lunch for the employee.

Most of the cost of that mandate is passed through to that employee in reduced wages. A review by Lewis-VHI of the literature on pass-throughs suggests that wages will on average be reduced by 88 percent of the employer's cost of a health care mandate.

Last December's Lewin-VHI analysis of President Clinton's legislation did not include an estimate of this wage affect associated with an employer mandate. It estimated only the net change in explicit household health care spending.

But a family could enjoy a small reduction in health spending, yet be hit by a far larger cut in wages. So we asked Lewin-VHI to reanalyze the Clinton plan, estimating the combined effects of changes in health spending and changes in wages. The results are quite startling and are included in my full written testimony.

In summary, the new analysis shows an employer mandate would cut wages in 1998 by almost $21 billion and cost between $150,000 and $350,000 jobs, generally among low-wage workers. Workers in firms not now providing insurance would face wage cuts averaging $1200 in 1998 under the Clinton plan.

When this hidden wage cut is included as a household cost of health care, which in reality it is, it turns out that rather than reducing household health spending in 1998 by $26.5 billion the drop under the Clinton plan would be only $7.7 billion.

This has a significant effect on the balance between winners and losers under the Clinton plan. The proportion of working age households whose total health spending rises by more than $1,000 under the Health Security Act jumps to 31 percent when wage affects are included, up from 17 percent when the affect is ignored.

No less than 53 percent of working age households would pay more under the Clinton plan in the form of direct health costs and wage cuts.

Now compare this with the Nickles consumer choice legislation. This bill would change the way in which Americans get tax relief for health care costs. It would replace the current exclusion for company-sponsored insurance with a new refundable tax credit for insurance from any licensed source, as well as for out-of-pocket expenses and contributions to a medical savings account.

Much like the child care credit, the health credit would be on a sliding scale based on income and total health costs. In addition, employees would have the right to cash out the actuarial value of their current employer-paid health plan, the value being based on age, sex and geography, and put as much of that money as they wished toward a health plan of their choice from some other organization.

They would have to obtain at least catastrophic insurance. Insurance underwriting for setting insurance premiums would be limited by law to age, sex and geography, not health status. Unlike today, families under the Nickles bill would enjoy full tax relief in the form of the refundable credit for a nonemployer plan.

What this means is that families could pick a plan and the health benefits they really wanted and keep the plan from job-to-job without interruption. The plan would be owned by them, not their employer, as is the case today.

Families could have a plan offered through a union, perhaps the Farm Bureau or a church, or for that matter their employer, with the same tax relief or direct assistance from the government. As you know, Mr. Chairman, many Federal workers pick union-sponsored plans under the Federal Employee Health Benefits Program, which is the model for the Nickles bill.

Lewin-VHI compared the impact of this tax credit program with the Clinton legislation and looked at the true bottom line, including the net impact on wages and direct health costs.

The analysis shows that under the Nickles tax credit approach, only 19 percent of working age households would see a net increase in costs of more than $1,000 compared with 31 percent under the Clinton employer mandate. Under the Nickles bill, 39 percent of working age households would experience a net reduction in costs of at least $1,000 compared with only 28 percent on the Clinton.

Furthermore, the Nickles tax credit approach leads to substantially more gainers in every income group, even including the working poor, than the Clinton employer mandate.

In conclusion, Mr. Chairman, the employer mandate approach to universal coverage involves large hidden costs on families in the form of pass-throughs, wage reductions. The tax credit approach, on the other hand, can achieve the same goal of universal coverage, yet do so while reducing net household health costs more sharply for all income groups and without the Clinton plan's huge health alliances, job killing employer mandates or destructive yet ineffective price controls.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Butler appears in the appendix.]

The CHAIRMAN. We thank you, Dr. Butler, for a concise and somewhat equivocal proposition. And we thank you for bringing to us the Heritage Foundation's suggestions for achieving universal coverage. Senator Packwood is sort of lost in some of those algebraic formulas.

Dr. BUTLER. So was I, Mr. Chairman.

The CHAIRMAN. Next we have Alain Enthoven, who is Marriner Eccles Professor of Public and Private Management at the Graduate School of Business at Stanford, and one of the founders of the Jackson Hole Group. Good morning, Doctor, once again.

STATEMENT OF ALAIN C. ENTHOVEN, PH.D., MARRINER S. ECCLES PROFESSOR OF PUBLIC AND PRIVATE MANAGEMENT, GRADUATE SCHOOL OF BUSINESS, STANFORD UNIVERSITY, STANFORD, CA

Dr. ENTHOVEN. Good morning, Mr. Chairman. It is a privilege to appear before this important committee, which is destined to play

a crucial role in health care reform; and it is a pleasure to revisit some friends of longstanding. I do not say old friends anymore. [Laughter.]

Especially the Chairman with whom I served in the administration of President John F. Kennedy.

The need for comprehensive reform is urgent now, this year. The high and rising costs of health care are straining public finances at every level of government and pricing coverage out of reach of moderate income families.

Cost containment and universal coverage are inextricably linked. A serious program of cost containment would produce morally unacceptable results if we do not protect people with low incomes and we will not be able to afford universal coverage without punitive taxes if we do not get the costs down.

In the 1950's and 1960's, America put in place a system of powerful cost increasing incentives in order to expand coverage and care. It is time now for us to reverse the incentives and to reward economical choices.

Per capita pre-payment versus the outdated fee-for-service remote third party payment system, with strong accountability for outcomes and consumer satisfaction, is what is needed to do this. Now we have about 45 million Americans in health maintenance organizations, so this is no longer an untried or exotic idea.

There are many ways to cut costs substantially without cutting the quality of care. I would be happy to expand on that. All of our experience tells us that market forces are what motivate quality improvement and cost reduction. Price controls simply do not work.

People are concerned about the ability to choose a doctor. We suggest requiring every sponsor to offer at least one plan with a point-of-service option. The lynch pin of incentives reform is a limit on tax-free employer contributions set at or below the price of the low-cost plan.

I know that this will be tough politically, but the tax cap is an idea whose time has come. First, it is needed for incentives reform. That is, when the health plan cuts its premium by $1 it needs to be able to transmit that dollar to the would be customer to induce the customer to join.

Second, it would be a way of bringing a huge Federal revenue loss, that is $90 billion in 1995, under congressional control.

And third, it would be an ideal source of revenue which we will need for assisting the poor, because it is a way of broadening the tax base without raising marginal tax rates.

The worst market failure we have is in the market for individuals and small groups, say up to 100. They are too small to spread risks, to achieve economies of scale and administration, and to offer individual choice of plan.

The best solution is the health plan purchasing cooperative and the cleanest and surest way is with exclusive HIPCs and mandatory participation. People do not like mandatory participation. But health insurance means pooling of risk and a voluntary purchasing cooperative is likely to die from a death spiral of adverse selection.

A strong incentive to participate is needed, such as to condition the tax break on participation, the idea that exclusive purchasing cooperative has aroused fear of the single payer and fear of the

DMV. I sympathize with both fears. But multiple competing HIPCs pose dangers of added marketing costs and a contest to select risks.

We do believe that we could accommodate the fear of the DMV by what we call a Post Office/Federal Express model in which the Governor creates Breaux-Durenberger purchasing cooperatives but others could create alternative HIPCs or cooperatives if they agree to play by the same rules so that HIPCs would compete only on customer service and administrative costs, not on selecting risks.

Medicare should be included in the reform system, otherwise it leaves too much of the market in the unreformed fee-for-service remote third party payment system.

As for universal coverage, we have a suggestion. Take as a point of departure the Breaux-Durenberger bill. That would be a big step forward for the poor. It would mean everybody up to the poverty line is covered with a full subsidy, and a sliding scale of subsidies from 100 to 200 percent. But we do acknowledge that it leaves people in the 100 to 200 percent of the poverty line income range with excessive implicit marginal tax rates or benefit reduction rates.

We ought to create a balanced health security budget for all government support to individual health insurance, including the revenues lost from the exclusion of employer paid health insurance from employee taxable income. And then we should expand the subsidies step-by-step to low-income people as the savings materialize.

We ought to commit that by a fixed date, perhaps the year 2000, Congress will meet a target, such as 95 percent of the population covered, or expand subsidies or impose a mandate.

We could debate and refine the mandate, but we do not have to decide the details now. If there were an employer mandate, it should include subsidies to targeted low income people in the form of vouchers that would be turned over to the employer.

What is universal coverage? I am not sure of the number, but the goal should not be 100 percent. Maybe it would be better to think in terms of 95 percent. There will always be some people whose life styles will not fit with signing up with a health plan.

There will always be a need for public providers of last resort, for undocumented aliens if none other, and we should not bend out of shape the system that would work for 95 percent of the people in order to accommodate the 5 percent who do not fit in.

This is the year to take a bold step, to get the system moving in the right direction—more economic choices, more cost consciousness, and more people covered. You should recognize that you will be back next year and every year with more legislation and we should not let the debate over the ultimate solution prevent us from taking urgently needed steps now.

Thank you.

[The prepared statement of Alain Enthoven appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Enthoven. I noticed that you are still fiddling with what is universal coverage. Your testimony has 97 but you said 95.

Dr. ENTHOVEN. I asked the Clerk to change it for the record.

The CHAIRMAN. No, that is all right.

Dr. ENTHOVEN. I think 95 might make it.

The CHAIRMAN. You are having to cite full employment goals.

Dr. ENTHOVEN. Right. Exactly. We need a practical, realistic——

The CHAIRMAN. How many people did the Census find in 1990, about 95 percent?

Dr. ENTHOVEN. Was it something like that? I know that we have problems counting people.

The CHAIRMAN. We always do.

Now Professor Graetz, who is Hotchkiss Professor of Law at Yale University, and also James Tobin. Is this a statement for yourself and James Tobin?

Mr. GRAETZ. Yes, Mr. Chairman.

The CHAIRMAN. Sure. I did not think you were the James Tobin Professor Emeritus of Economics. That would be too much. You would be overachieving. [Laughter.]

Mr. GRAETZ. James Tobin is the James Tobin, Professor Emeritus of Economics. [Laughter.]

The CHAIRMAN. Good morning.

STATEMENT OF MICHAEL J. GRAETZ, J.D., JUSTUS S. HOTCHKISS PROFESSOR OF LAW, YALE UNIVERSITY, NEW HAVEN, CT

Mr. GRAETZ. Good morning. Thank you. It is a pleasure to be here today to discuss the subject of health care reform. My statement is on behalf of myself and my colleague, Jim Tobin.

First, we believe that all Americans should be entitled to receive adequate medical services without regard to their ability to pay or their health status. It is individuals who get sick and need medical services. Individuals and families ability to pay is the natural criterion of equity. It is individuals who must be guaranteed coverage. So it is individuals who must be required to have insurance.

The only sensible reason for linking health coverage to employment is that much health insurance coverage is now provided through employment. Employer mandated health insurance has far less to do with where we should be taking health care reform than with where we are now.

Expanding, rather than abandoning employer based medical insurance increases the risks that major health reforms enacted today will fail in the long run to provide the secure, portable, adequate, reasonably priced and universal medical care that we all want.

President Clinton has often emphasized the need for individuals to develop skills and become flexible in the face of the changeable modern job market. He points out that workers now should expect on average to change jobs eight times. But he fails to recognize the irony of attempting not only to sustain but indeed to expand employer based health insurance as America moves into the 21st Century.

The principle political advantage of requiring employers to pay for their employees' health insurance is that it hides who bears the actual costs of that insurance. The fact that employers write the checks for medical care does not mean that they bear the full costs.

In the long run, costs are generally shifted to workers in reduced take-home pay and perhaps to some extent to consumers and higher prices.

Let us not be deceived that the choice before the committee is between an employer mandate and an individual mandate.

As the Clinton's health reform proposal makes clear, an employer mandate also requires an individual mandate. The real choice is whether to have a mandate only on individuals or on both individuals and employers, not whether to put mandates on employers instead of individuals.

Let me now discuss briefly the two aspects of the employer mandate—administration and financing. There appear to be two administrative advantages in the desire to link health insurance and employment.

First, collection of health insurance premiums can be facilitated by requiring employer withholding. Second, a variety of health insurance plans can be presented to individuals at their place of work and they can select what coverage to buy there.

Both of these administrative advantages can be realized whether or not any burden of employer financing is imposed. Proponents of employer based financing seem to see two principal advantages.

First, it locks into place existing payments made by employers who now provide health insurance for their employees.

Second, it hides the cost of financing additional coverage since wage earners and consumers fail to understand the economic burdens of employer financing on themselves and instead believe these burdens are borne by someone else.

The first of these benefits, locking in existing employer contributions, can be retained through a transitional requirement that employers who now provide health insurance to their employees be required to continue to do so.

The second alleged advantage is, in fact, a disadvantage. One of the major problems with the existing system of financing health insurance in this country is that it hides much of the costs. The invisibility contributes to rising costs.

On the other hand, there are many disadvantages to employer-based financing. First, for employers who want to circumvent such a mandate, there are incentives to use part-time workers, temporary and seasonal help, overtime, to engage in cash transactions off the books, to hire single persons rather than heads of families, and to classify people as independent contractors instead of employees.

Second, coupling employer financing mandates with employer based subsidies inevitably produces inequitable and arbitrary results. Individuals will be treated differently based upon the type of employer for whom they work and on that employer's circumstances.

The adverse consequences of employer mandates will be greatest for marginal businesses and marginal employees. Families will be treated differently, depending on the number of employed members, whether they work full or part-time and how often they change jobs, work locations or places of residence.

A flat rate payroll tax on employers would have major substantive advantages over the complex system of mandated payments and wage caps of the Clinton plan. With an individual mandate, government contributions to the cost of health insurance can be targeted based on income and need. And an individual based

system can and should treat self-employed persons the same as employees.

The major concern with individual mandates seems to be about administering the system. However, it is important to remember that tracking individuals, their payments and their subsidies, and their health insurance coverage cannot be avoided by mandating employer financing.

The problems of enforcing an individual mandate do not simply disappear by coupling an individual mandate with an employer mandate as under the Clinton plan.

Professor Tobin and I have suggested elsewhere that one health insurance option available to all Americans should be like Medicare for those under age 65. It would offer the basic medical insurance package with premiums that in total would cover the costs.

The Federal Government should also extend to any American the choices that are made available to its employees under the Federal Employees Health Insurance system. Then anyone could purchase health insurance through a system that offers a great range of health insurance plans in virtually every locality.

Private health plans could also offer the same package of health care benefits, but no one would be allowed to pick and choose members or to charge premiums that are greater for riskier individuals or families.

Federal subsidies to individuals could take the form of refundable tax credits or vouchers or if something new were desired, these subsidies could even be in the form of health insurance credit cards.

For low income families the subsidies would probably cover the entire premium of the basic package. Most other families would receive vouchers at least as valuable to them as the current tax exemption for employer provided insurance. No family should face an out-of-pocket cost of more than 10 percent of their income for the basic package.

Let employers help pay the premiums if they wish, but count these premiums as taxable income. Finally, employers who now offer coverage to their employees should be required to continue to offer coverage during a period of transition.

An individual mandate offers great flexibility about the institutional arrangements through which people might obtain insurance. If Congress so desired, health alliances along the line that President Clinton has proposed could be created or voluntary health insurance purchasing cooperatives along the lines proposed by Senator Chafee, Senator Breaux, Senator Durenberger and others could form.

By requiring the Federal Government to offer Medicare-like coverage to all Americans, as well as giving everyone the same choice as are available to Federal employees, and by explicitly limiting the growth rate and the per capita costs of these Federal programs in the legislation, the need for caps on private insurance premiums along the lines of the Clinton plan could be avoided.

People could change health insurance plans annually. If private costs rise faster than the government options, people will select from the government's menu. On the other hand, when the private

sector is more successful at keeping costs down and quality up than the government, people will shift to private plans.

The budgetary score keeping role now being played by premium caps would become unnecessary. The government would have to keep its own house in order, a large enough chore, but price controls would become unnecessary surplus.

Our proposal borrows features from plans offered within the Congress across the political spectrum. A victory for it would be a victory for the American people and a demonstration of effective bipartisan governance.

Thank you.

[The prepared statement of Mr. Graetz appears in the appendix.]

The CHAIRMAN. Thank you, Professor. Would you give the committee's particular thanks to Professor Tobin for his contribution.

Alain Enthoven and I will recall when President Kennedy called him up at Yale to ask if he would be a member of the Council of Economic Advisors. He said, well, Mr. President, you know, I am kind of an "ivy" tower economist. And President Kennedy said, you know, I am kind of an "ivy" tower President. They got along very well. [Laughter.]

And now, Dr. Holahan on behalf of the Urban Institute. Good morning, sir.

STATEMENT OF JOHN F. HOLAHAN, PH.D., DIRECTOR OF THE HEALTH POLICY RESEARCH CENTER, THE URBAN INSTITUTE, WASHINGTON, DC

Dr. HOLAHAN. Good morning, Mr. Chairman. What I would like to do and what I have done in my testimony is discuss the advantages and disadvantages of both employer mandates and individual mandates and suggest an approach which I think combines the best of both.

The advantages of an employer mandate are first that it retains the financing in an administrative capacity that is already in the system. Sixty-five percent of non elderly Americans with insurance and 85 percent with private insurance now get it through their employer. The employer mandate clearly builds on this capacity.

Second, there is less redistribution of income among Americans with an employer mandate. And third, I think that it is almost certain to be easier to enforce an employer mandate.

The disadvantages of an employer mandate are the possible affects on jobs. Most of the research evidence that I have seen indicates that these effects are likely to be fairly small in the long term. Rather, employers will shift the cost of the mandate to workers in the form of lower wages or in some cases on to consumers and higher prices.

But in the short term, it is likely that there will be some job losses because it takes time for employers to adjust wages or to increase prices.

It is important to remember, however, though that there are many other firms that will have lower costs under a reformed health care system because many of the dependents that the firms now cover will be covered by another employer and they will no longer be paying for uncompensated care. In these firms there

should be an increased demand for labor, with positive affects on wages and employment.

The real effect of an employer mandate is on wages. An employer mandate is really a fair regressive way to finance health care. To deal with the problems with wages and jobs the Clinton Administration has proposed a system of subsidies to employers. These subsidies are very costly in the Clinton plan. They are poorly targeted. They will benefit high income workers in low wage firms and not benefit low wage workers in the high wage firms that are not eligible for the subsidies. They will be complicated to administer because the subsidies vary with firm size and with payroll.

A final problem with an employer mandate, as was mentioned earlier here on this panel, is that individuals have come to really believe that someone else is paying the bill. For these reasons, people have become attracted to individual mandates. The advantages of individual mandates are clearly that there is no direct effect on jobs or wages and the financing of the system can be more progressive if there are adequate subsidies for low-income people.

The disadvantages are, first, that I think it would be harder to enforce most individual mandates. This is particularly true with smaller voluntary alliances. Second, the costs are likely to be high, particularly when firms with low-wage workers drop coverage so that those workers will be eligible for subsidies.

And, third, there is a high marginal tax rate on additional earnings. The subsidies are phased out as income increases. In these income ranges people also lose the earned income tax credit, begin to pay payroll taxes, and begin to pay Federal and State income taxes. It has been estimated that the marginal tax rate on additional earnings in this range is as high as 60 percent and perhaps higher, thus creating a serious disincentive to seek work. This problem with the marginal tax rate can be fixed, but only with a slower phase out of the subsidies which will cost the government more money.

One solution that I find attractive is an employer mandate with a 50 percent contribution by employers, coupled with a mandate on individuals to pay the balance of the bill, depending on the plan that they choose. This would be coupled with subsidies for the poor and near poor up to about 250 percent of poverty.

There would be no cap on the employer contribution. There is less need for this with the 50 percent employer contribution. There may be some need for temporary assistance in the short run for very low wage firms.

I think the advantages of this approach are first that it targets all the subsidies on low-income people. Second, it is less costly than under the Clinton plan because the subsidies to the poor are more than offset by the reductions in the employer subsidies. Third, it is also less regressive as a means of financing than a pure employer mandate.

Fourth, there is a lower tax rate on additional earnings than under a pure individual mandate. Fifth, all firms are treated the same with a 50 percent contribution. Their contribution does not vary with the firm size or with their wage levels. And finally, I think the most important advantage of this proposal is that individuals and employers would both have a substantial financial

stake in supporting the government or private payers in containing costs.

Thank you.

[The prepared statement of Dr. Holahan appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Holahan.

Just a point of information. We have been discussing this question of what is universal coverage. The Social Security system today covers 95 percent of workers. That is 60 years into an effort and a coverage which I think now is at least nominally universal. I mean, in what we think to be a universal system, we get 95 percent and that is pretty good.

Senator GRASSLEY. Mr. Chairman, is that 95 percent of people or 95 percent of income?

The CHAIRMAN. Of workers, persons who are required to pay the tax. And the Census Bureau is getting better by the day. I guess they missed only 1.5 percent of the population in the last Census count.

Dr. ENTHOVEN. I understand that in Hawaii where they have had an employer mandate for some time that effectively the coverage is on the order of 90 percent.

The CHAIRMAN. Yes.

Dr. ENTHOVEN. So there is a lot of leakage and circumvention.

The CHAIRMAN. We understand that and we do not want to set ourselves goals which we are not going to reach.

Could I just ask one question of each of the panel and then turn to further questions? Could I just ask Dr. Butler, Dr. Enthoven, Mr. Graetz, Dr. Holahan, would you agree we ought to set a goal with respect to universal health care coverage? Dr. Butler?

Dr. BUTLER. I certainly think universal coverage for those who want to be covered, certainly. That would not be 100 percent.

The CHAIRMAN. If it is against your religion, we understand.

Dr. BUTLER. Or you are a libertarian motorcyclist, to use your example. But I think we would want to do that. Of course, as we all know, the issue is universal coverage for what? Certainly I think universal coverage against health costs that otherwise could bankrupt seriously.

The CHAIRMAN. But it is not now a stated national policy.

Dr. BUTLER. That is correct.

The CHAIRMAN. Dr. Enthoven?

Dr. ENTHOVEN. I think it is important to achieve universal coverage, because as I mentioned in my remarks, if we have a serious program of cost containment, then it is going to be very important for health care providers not to provide for people who cannot pay and we will get morally unacceptable results.

So I think it is important to include everybody in. In the case of Stuart's example of people who choose not to be covered, the problem with that is they choose not to be covered until they have crashed on their motorcycle some place, then they get taken to the emergency room at Stanford Hospital and they cannot pay. And those of us who paid our premiums and our taxes are forced to pay for them. So they are compelling us, in effect. I think it would be appropriate to have a free rider tax to discourage that and to col-

lect funds so that for those who chose not to be insured there would be a way of paying for them.

The CHAIRMAN. Putting aside some marginal cases, as a national policy you think there should be an enunciated goal.

Dr. ENTHOVEN. Yes.

The CHAIRMAN. Mr. Graetz and Dr. Tobin?

Mr. GRAETZ. Yes.

The CHAIRMAN. Why can lawyers be so succinct? [Laughter.]

Dr. Holahan?

Dr. HOLAHAN. Yes. I think that that should be the goal. I think that you are quite correct that we will probably never achieve it.

The CHAIRMAN. No, you have achieved it when you are at 90–95 percent.

Dr. HOLAHAN. Okay. Fine.

The CHAIRMAN. You feel it should be a stated——

Dr. HOLAHAN. I think the principle is that every American should be required to pay, whether you can actually do that or not.

The CHAIRMAN. Thank you.

Dr. HOLAHAN. There should not be free riders. I think it is important to recognize that this catastrophic system, this hidden ability to obtain care is really going to quickly go away as we are more and more successful in containing costs. It really will not be there.

The CHAIRMAN. Thank you very much.

Senator Dole, you have been a faithful attendee of these hearings.

Senator DOLE. Can I wait a while?

The CHAIRMAN. Yes, of course you can. You always do. We give all our leaders time.

Senator DOLE. I figure we will get all the easy questions out of the way. [Laughter.]

The CHAIRMAN. The easy questions out of the way.

Senator Packwood?

Senator PACKWOOD. Let me ask, Dr. Butler, I was a little confused by your answer. You said, yes, you favor universal coverage for those who want it. That seems to me a contradiction.

Dr. BUTLER. No, I meant to draw a distinction between those who, for whatever reason, are determined not to avail themselves of any health insurance, of any tax benefits and so forth. I think we have to be realistic that to try and have a policy that would include all of those would be rather difficult.

But I mean to all intents and purposes I agree with the Chairman's point.

Senator PACKWOOD. All right. Dr. Holahan, you kind of tilt toward what I would regard as somewhat the German system. You have the employers paying 50 percent of the cost of the premium, right?

Dr. HOLAHAN. Yes.

Senator PACKWOOD. But the employee purchases the insurance wherever he or she wants?

Dr. HOLAHAN. That is correct. So it may not be 50/50. I mean, depending on the plan that they chose. If it shows a very expensive plan, they could be paying slightly more than half the cost.

Senator PACKWOOD. The individual would?

Dr. HOLAHAN. The individual would.

Senator PACKWOOD. So you are saying that it is not 50 percent of the premiums, it is 50 percent of a flat base of some kind.

Dr. HOLAHAN. Fifty percent of, say, in the Clinton Administration's concept of a weighted average premium, of a bench mark premium.

Senator PACKWOOD. All right. You want, then, the employee paying a higher percentage?

Dr. HOLAHAN. That is correct.

Senator PACKWOOD. Now that means you are going to have the employer paying out premiums, if you have 300 or 400 employees, to perhaps 50 or 60 different insurance plans.

Dr. HOLAHAN. I am thinking of this within the alliance structure of the Clinton Administration. So those payments would go to the alliance.

Senator PACKWOOD. To the alliance only?

Dr. HOLAHAN. Yes, sir.

Senator PACKWOOD. All right.

Dr. HOLAHAN. I think you could probably do it under other structures, but I have not thought about it that way.

Senator PACKWOOD. Let me ask both Dr. Enthoven and Michael Graetz, in your individual mandate, would you have the employer pay anything?

Mr. GRAETZ. Senator, if you want employer based financing the cleanest way to do it, which is in fact the way the Germans do do it, is through a payroll tax, that is a levy on payroll. If you need additional moneys, I think you can do it based on Professor Tobin's calculations. I think that you can finance this plan simply by repealing the current exclusion for health insurance and converting it into a series of tax credits plus the additional moneys that are made available through the Clinton program.

So I do not think you need a payroll tax. But if you need employer based financing, the clean way to do it is by imposing a payroll tax that is a flat rate of payroll rather than one that varies dramatically as all of these other options do.

Senator PACKWOOD. That is what Germany does. It is a payroll tax. You pay it to one of their sickness societies.

Mr. GRAETZ. That is correct. The German payroll tax varies, depending on the cost of insurance.

Senator PACKWOOD. The benefits are roughly the same, but they vary because of the demographics of the make-up of the plans.

Mr. GRAETZ. That is right, and the range is fairly large in the German payroll tax.

Senator PACKWOOD. But you would get rid of the payroll deduction for health insurance and say that, in your judgment, makes enough money to take care of whatever subsidies you are going to have for individual policies?

Mr. GRAETZ. Well, what I would do is eliminate the employee exclusion—that is, I would treat employer purchases of health insurance the same as cash wages. So essentially they would be deductible by the employer in the same way that cash wages are.

Senator PACKWOOD. I am confused now. You have an individual mandate.

Mr. GRAETZ. Yes.

Senator PACKWOOD. Which says to Sally Smith or Johnny Jones, you must buy an insurance policy that has the following benefits. Go out and buy it where you want but the policy must provide that. How is that paid for?

Mr. GRAETZ. It is paid for by the individual.

Senator PACKWOOD. All right.

Mr. GRAETZ. But we have in our plan two constraints. The first constraint is that no family would have to pay more than 10 percent of their income for health insurance. The second constraint is that—at least for people up to the 28 percent tax bracket—they would receive a tax credit that was equal to them in the amount of the income tax exclusion that they now get of health insurance when the employer provides it.

So to the extent the employer is providing health insurance, it would be taxable as cash wages, but they would then get a credit against their income tax for those wages.

Senator PACKWOOD. And you figure it would be about a wash for the people up to the 28 percent level?

Mr. GRAETZ. For the people at the 28 percent level, they would be made no worse off. And to the extent that we include in this proposal controls on costs, they would be better off, obviously. So that according to our numbers people at about $100,000 of income and below would be fully protected against any income tax increase.

Senator PACKWOOD. Dr. Enthoven?

Dr. ENTHOVEN. I have to plead guilty to learning something from the debate. In previous writings I rather favored the continuation with the employment based system for reasons that people mentioned. But increasingly, I appreciate the validity of the arguments for the individual mandate.

I have been a critic of the employment basis of health insurance saying, for example, it is arbitrary. You lose your health insurance when you lose your job.

But we do need a group basis for health insurance. I somewhat changed my attitude about the employer when I looked at the alternative, which is the government. I just do not favor the single payer approach and I do not favor any approach that is going to lead us to that because I think then we have serious problems of constituent pressures for special favors and the like.

So I think that it is important to find a way to keep private employers in there, to keep pluralism on the demand side for the sake of innovation and competition.

So from that point of view, I think we need to recognize that private employers have some virtues compared to the single payer.

Senator PACKWOOD. But I do not quite understand the answer. Does the employer pay part of the premium of the individual's policy?

Dr. ENTHOVEN. Well, I agree that the idea of employer paid health insurance is a myth. I agree with the other panelists that that is going to come out of the employee's wages. It is possible that in a combined mandate you might want to require the employer to earmark some of the employee's total compensation in the form of health care as an incentive for the employee to buy it through that group, as a way of having that as a group basis for health insurance.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Packwood.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you.

Gentlemen, at one of our hearings last week someone made the observation that this health insurance topic that we are debating is really a function of income, not of employment. It is not that dramatically of different way to look at it, but it is probably an important way for all of us to look at this, that what we are dealing with here—health universal coverage through a health plan or access through that kind of a system—is really an income security problem not an employment problem.

If that, in fact, is true, then one of the issues that is not well debated, I suppose, is when we talk about universal coverage are we talking about universal coverage of financial risk or are we talking about universal coverage in the sense that everybody is going to own the same plan and everybody is going to get basically the same subsidy for that plan.

As I try to learn from the debate as all of us do, one of the distinctions between the catastrophic approach and some of the other approaches to this seems to be that if Stuart Butler or Don Nickles were to set a goal they would say we want to get to equal access, to the highest quality care for all Americans through a system of universal coverage of financial risk. They would then set up a system in which each person would make a decision about how to get there.

Maybe I will ask this question first of Alain Enthoven. Others seem to be either ambivalent about that subject or they have a different definition of universal coverage or they are also trying to use the system to do something else which is a reform of the way in which we actually deliver our care.

So, Alain, would you take on that subject? What should be the appropriate goal? We have agreed on the numbers now at 95 percent. But is it universal coverage of financial risk or is it something else?

Dr. ENTHOVEN. I think it is very important to reform the delivery system and to use individual free choice and market forces to get us there as market forces have been doing already. That is, I think that the traditional fee-for-service, solo practice, remote third party payment system was in effect a figment of the medical profession many years ago, foisted on us with coercive tactics on their part because it is an open-ended entitlement for doctors.

It has proved to be entirely dysfunctional because all the incentives are cost increasing and there are no rewards for economical behavior. I believe as I have seen happen in California that given informed responsible choices, increasing numbers of people will migrate to plans that do a better job of controlling cost, usually based on per capita prepayment.

As I say, I believe that there is a very great deal that could be done to give us a high quality but much less costly form of care in a reformed system. So I think that a key part of the picture must not be just insurance for everybody. We have to keep in mind the need to have a reformed system.

Senator DURENBERGER. And, Stuart, what I hear Alain to say is that if you allow everyone to just make the $1,000 worth of decisions themselves, you do not have much help in making those decisions. That somewhere in this system as we try to change the system, we need a more comprehensive approach to decisionmaking about what services are actually necessary and what are appropriate.

And that if we go into the system with our money being the first $1,000 and then somebody else kicks in after then, we also run the risk of looking like the person who has to pay the first $5 or $10 of every restaurant meal, but then everything over that is paid for by somebody else.

How do you react to Alain's argument?

Dr. BUTLER. Well, I would put it slightly differently because I think that just in terms first of all of what our objective is, I think our number one objective is to reach a situation where Americans are not going to be wiped out financially by heavy costs. I think we would all agree, certainly most Americans agree, that is a top priority.

With respect to how people choose to buy services, I think you have a dilemma there. If you try to say people ought to have in some package a certain specific set of services of the most routine variety, as well as catastrophic coverage, then you get into the problem that we are all well aware of. What is it going to be?

You are going to get pressure from various people in the medical profession to include their services. The cost is going to go up and I will have to buy a plan which has certain services in it I do not want, and certainly do not want to have insurance coverage for, and yet it may not have services in that I would like to have, because the government has decided that is not in the basic package.

So the idea of a standardized package, I think, has lots of problems with respect to what services people actually get. With respect to your question of how people choose, I think it is very clear that if you give people some subsidy for buying benefits that they can choose, such as a tax credit, but allow them a fair margin of discretion about exactly what structure of benefits they can get, I think people are pretty capable of making those kinds of decisions.

People make decisions every day about which pediatrician to have, what level of dental coverage and so forth. I do not think these are things that are beyond the——

Senator DURENBERGER. They may make a choice about which pediatrician, but they make no choices about the pediatric services.

Dr. BUTLER. No. But they may make some decision about some level of service and how much is covered by insurance and how much is not. They can and do make that decision routinely.

Dr. ENTHOVEN. Based on my practical experiences as Benefits Chairman at Stanford and as Chairman of the Health Benefits Advisory Council for CALPERS where we run a large scale multiple choice competitive model, I can tell you, ordinary people cannot understand the coverage provisions of the contracts. The experts cannot.

I persuaded the PERS Board to adopt standardization in that group and now we are trying to carry it out. And experts on my advisory panel and in the management of the system, we sit

around and we look at these contracts and we say, what on earth does this mean. Perhaps these are arcane words that came from some lawsuit way in the past.

Experts have a very hard time understanding it. In fine print, a lot of people just do not understand enough to read the fine print. When we were doing our standardization, one of the plans said "we cover organ transplants," but in the fine print it says, "we do not pay for harvesting and transplanting the organ."

So I am telling you, people who are really expert in this business have a very hard time figuring it out. I believe in individual autonomy. People ought to have choices, but this is——

The CHAIRMAN. Dr. Enthoven, once again, harvesting the organ?

Dr. ENTHOVEN. Yes. [Laughter.]

Dr. BUTLER. They use that term at Stanford, Mr. Chairman.

Dr. ENTHOVEN. Your motorcyclist——

The CHAIRMAN. What would we do without motorcyclists? [Laughter.]

Dr. BUTLER. Could I just respond very quickly?

The CHAIRMAN. Nature has it way. It is a very complex system. [Laughter.]

Dr. BUTLER. Senator Durenberger, could I just respond very quickly to that because I understand insurance fine print is enough to befuddle anybody. However, practically every member of staff behind you, and all the members on this committee, I suspect, pick plans every year with very different benefits in them, from different types of delivery systems, with different levels of dental care and so forth. You seem pretty capable of doing that. And I suspect the rest of us could probably do the same thing.

Dr. ENTHOVEN. But it is in a system that is noncompetitive because there is a lot of market segmentation and in which there are spirals of adverse risk selection because some of the plans design benefit packages that are deliberately designed to select the good risks and be unattractive to the bad risks.

Dr. BUTLER. But the system has survived for 34 years.

Dr. ENTHOVEN. It could be better.

The CHAIRMAN. There we are.

Mr. Graetz?

Mr. GRAETZ. Yes, thank you. I think that the answer to Senator Durenberger's question is that we really do need to be pooling health risks in this system. I think that what we are now talking about is the question, what would you mandate? In think catastrophic coverage is really not enough. There is a very tough judgment call here. We are not going to mandate that people get all care which is beneficial that costs less than the benefits. We are not going to make people go get prenatal care or mammograms.

On the other hand, we really do need to pool those health risks and make sure that they are covered for those things.

The CHAIRMAN. Right. Thank you.

Mr. Holahan?

Dr. HOLAHAN. Just one point. I would say that I just completely agree with what Alain Enthoven has said on this. I mean I think one of the great contributions that Dr. Enthoven has made is that you are not going to have effective competition in this health care

market without standardization of benefits, easily accessible information, and cost sharing that is easy to understand.

When you can vary benefit packages and have catastrophic plans available to some people and not to others, I think it gets extraordinarily complex and the likelihood of competition being successful is probably very low.

The CHAIRMAN. Which is the other. Thank you.

Senator Chafee is next.

Senator CHAFEE. I am ready if you want. But, Bob, if you want to go ahead.

The CHAIRMAN. Senator Dole?

Senator DOLE. Could I just followup under the Nickles plan which I am a cosponsor? There is a tax credit. What is the tax credit for?

Dr. BUTLER. What elements does it include?

Senator DOLE. Yes. It was a basic benefit package or——

Dr. BUTLER. It would be a tax credit for all insurance that you purchase, for out-of-pocket expenses and for contributions to a medical savings account. It would not be limited to a specific package of benefits, although you would have to include at least catastrophic in insurance.

Senator DOLE. That effect is a basic benefit package?

Dr. BUTLER. Oh, it is a minimum benefit package. That is correct. But there is a very important distinction between a minimum requirement and a standard benefits package. I think that is a very important distinction.

Senator DOLE. That is one of the debates we are going to have, whether we take 60-some pages to list all the benefits as we have in the Clinton bill.

Dr. BUTLER. Right.

Senator DOLE. Or whether we have a Board as we have in the Chafee bill or whether we have the approach that you have or whether we have a dollar amount and people can decide what they want. I think that will be resolved, but it is certainly very important to do it, it seems tome.

The other three, as I understand, agree there should be some basic benefit package. Is that correct?

Dr. ENTHOVEN. Yes.

Mr. GRAETZ. Yes.

Senator DOLE. Tell me a little more about the FEDMED plan. Has that been drafted?

Mr. GRAETZ. The FEDMED plan is essentially a plan which would allow people to——

The CHAIRMAN. That is a plan that Mr. Tobin proposed.

Senator DOLE. Right. It is in the statement that Mike gave, yes.

Mr. GRAETZ. This plan is essentially a plan that would allow people the option—people who are not now eligible because they are not at age 65—allow them the option of purchasing Medicare-like coverage at full cost, so that the total costs would be equal to the costs of the plan. It would not create any subsidies specially for that plan.

We would also allow people to select among the same package of benefits that are given to Federal employees under the Federal Employees Health Benefits Program, so that the Federal Govern-

ment would be offering people an opportunity to buy through either a Medicare based system or through purchasing arrangements with other private insurers that would give everyone a centralized way of purchasing their insurance and would minimize the need for some of these State alliances and so forth.

This health insurance would be completely portable so that when somebody moves from one State to another or changes jobs, they would not have to worry about losing coverage or changing their insurance coverage, simply because they changed employment or place of residence.

Senator DOLE. Let us say there are not enough votes for employer mandates and not enough votes for individual mandates; then what happens?

The CHAIRMAN. Then we split the difference.

Senator DOLE. No, there are not enough votes for that either.

The CHAIRMAN. Oh. [Laughter.]

Senator DOLE. Because we have in all these now we have them both. You had an AD–20, that is an individual mandate, 20 percent, 80 percent on the employer—50 whatever it is. I have to go back and read yours again. I do not understand yours, but it is not a requirement in what we do here. [Laughter.]

Senator DOLE. How do we work it out?

Dr. BUTLER. There may be votes for an approach that helps people who need assistance to buy at least basic coverage to such a degree that you get something close to 100 percent coverage. It may involve such subsidies that people will in fact obtain coverage that they feel are denied today.

Senator DOLE. And the other thing is, if we do not have the votes for either the individual or the——

Dr. ENTHOVEN. Well, that is why I suggested in my remarks, start with something like Breaux-Durenberger, recognizing that initially the marginal tax rate, benefit reduction rate is too high. But as money comes in from savings, then start expanding the help to low income people, move the zero point for subsidies out, as Senator Chafee has proposed to 2.4 times the Federal poverty line and get the benefit reduction rate down to an acceptable point.

And people above that income, of course, benefit from a substantial tax subsidy. You would say whether they or their employer bought it they get the price of a low priced plan or whatever the tax cap is, they get that much tax free, so that gives them an incentive to buy.

Mr. GRAETZ. Senator Dole, at a minimum, the Senate has passed before major reforms in the health insurance market which eliminate medical underwriting, which require portability, and which eliminate insurance companies' ability to exclude people who have preexisting conditions.

There are a lot of improvements that can be made short of universal coverage. On the other hand, I think that the appropriate goal that the legislation ought to reach for is universal coverage. But if your question is, if we do not have the votes for that, what do we do, I think there is still a lot of good that can be done.

Senator DOLE. I do not know where the votes are, but I think just listening to people on each side, I think there are a lot of prob-

lems. When you come from a small State, a small business, you are going to have trouble with the employer mandates.

I can already see the TV ads saying, well, they do not want your boss to pay for this, they want you to pay for this. So there goes the individual mandates. I think some plans are getting ready to drop the individual mandates.

So I think that is one of the real issues. We will probably settle that at the retreat, right?

The CHAIRMAN. Yes, sir. That is the Dole-Packwood proposal to close down television. [Laughter.]

Senator DOLE. Right. Well, that would be helpful, too. [Laughter.]

Under the FEDMED plan what happens to all the self-insured? You are not assuming we——

Mr. GRAETZ. Employers would continue to be allowed to provide insurance for their employees. And if they wanted to pay for it, they would be allowed to pay for it. In fact, during a transitional period—I do think you have to move to this system gradually—but I think the question to ask is, do we believe that an employer based system is the right system for the 21st Century.

Our answer to that is no, that it ought to be an individually based system. The question then becomes how to get there. At least during some transitional period, we would impose a maintenance of effort requirement which would say that the employer either must continue to provide the insurance that is now being provided or substitute cash wages for that insurance.

So that the employee would then have the money to pay for insurance. For those people who are now covered through employment, we believe they need to be protected as you move away from an employment based system into something that is individually based.

Mr. GRAETZ. That is included in the Nickles legislation as well, Mr. Chairman, a maintenance of effort requirement on the employer.

Senator DOLE. And the other people are going to get the same choice that we have, right?

Mr. GRAETZ. Right.

Dr. ENTHOVEN. One of the things that concerns me about minimizing the need for State alliances is it sounds to me a little bit like the Federal Government is going to become the grand alliance. That is, somebody has to run the overall system and, as you know, set and enforce the rules, qualify health plans, and present the choice to people.

Our thinking is, we ought to keep that much more decentralized and not pull that all into the Federal Government.

The CHAIRMAN. Thank you.

Could I just ask one question? CALPERS cut its premium this year, did it not?

Dr. ENTHOVEN. Yes. We were very pleased to announce that this year for the coming year our weighted average premium is down by 1.1 percent.

The CHAIRMAN. Did everybody hear that? Senator Dole, did you hear that?

Senator DOLE. Pardon?

Dr. ENTHOVEN. The California Public Employees Retirement System in which we provide market coverage for 920,000 people in over 900 employment groups, this year for the coming year our average premium is down by 1.1 percent.

Mr. GRAETZ. Mr. Chairman, just in terms of Dr. Enthoven's idea that we are trying to put everything in the Federal Government, that really is a mistaken view of this plan. I would be very happy for CALPERS to offer the same package it offers to the California State employees to everyone either in California or in America.

The idea is for people to have many ways to buy insurance. Under our plan, the Federal Government is already providing insurance choices with respect to their employees, we suggest they extend the option to everyone and with respect to Medicare, it would give people another option to buy health insurance through the government.

But there is no reason to believe that on a voluntary basis the government becomes a monopolist. This is not single payer in drag.

The CHAIRMAN. This is an option, right. We will have none of that. [Laughter.]

Senator Baucus?

Senator BAUCUS. Senator Chafee is ahead of me, is he not?

The CHAIRMAN. Well, Senator Chafee yielded his slot to you and then Senator Chafee is next.

Senator BAUCUS. Well, if you want to go ahead, go ahead. Why do you not go ahead?

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Let me return to a question that was previously asked because I want to make sure I get the answer. Please do not extend your answers.

If we do not have a uniform benefit package, do we not inevitably have adverse selection? In other words, if you have a choice of packages out there, you are going to have adverse selection, at least I believe. Now,yes or no.

Dr. ENTHOVEN. Yes. The answer is yes.

Mr. GRAETZ. I agree, the answer is yes.

Senator CHAFEE. Yes. Thank you.

Dr. HOLAHAN. Yes.

Dr. BUTLER. To some degree.

Senator CHAFEE. Yes.

Dr. BUTLER. Well, yes, to some degree. [Laughter.]

The CHAIRMAN. Mark that down.

Senator CHAFEE. The answer is yes. On to the next. Next week we will see you here.

Now, Dr. Butler, what you are suggesting, as best I can understand it, is you do not want the government responding to special interests and that is why you have some concerns about the uniform benefit package.

Dr. BUTLER. Well, it is not the only reason. I think that——

Senator CHAFEE. But that is a concern?

Dr. BUTLER. It is a concern.

Senator CHAFEE. Now I do not quite understand how you can even have that concern or why your package is any different, because you have a catastrophic package. And, obviously, as soon as Congress gets its hands into that catastrophic package, they are

going to say you have to cover chiropractors, you have to cover podiatrists, so forth and so on.

Dr. BUTLER. Well, I do not think that will be the case. Let me explain what would happen for providers under the Nickles system. There would be a requirement for catastrophic coverage, which is essentially a stop loss on total expenditures by a family.

You would have to have certain basic services in that, such as emergency care and so forth.

Senator CHAFEE. Sure.

Dr. BUTLER. However, any specialty group would be able to market its services through a plan to consumers and those consumers would be eligible for a tax credit, no matter what that group was. So there is not the cutoff in the tax credit as there is in the case of a standardized benefits package.

Senator CHAFEE. But it seems to me that—and I have heard Senator Nickles who is very eloquent on connection with this plan and there is a lot of merit to it—you say that the government is not going to be involved with your plan and you do not have a uniform benefit package, but you do have a uniform benefit package.

You say it is a minimal uniform benefit package. The chances of the government getting into your plan are just as great as they are getting into our plan or anybody else's.

Dr. BUTLER. I do not agree they are just as great, Senator, because in the case of a standardized benefit package where that is just the one package that you can get tax relief for. If you are a provider, you must get in that package, otherwise it is financial death to you. The reason is that if you are not in standard benefits package, your customers, your patients, get no tax relief whatsoever for buying your service. I think there is a much more powerful incentive for those specialty organizations get into that benefits package than if the patients can get tax relief if they buy their services.

Mr. GRAETZ. Senator Chafee?

Senator CHAFEE. Be very brief.

Mr. GRAETZ. With a catastrophic plan, you have to decide what $2,500 of expenditures counts.

Senator CHAFEE. Sure.

Mr. GRAETZ. And you have to make exactly the same decisions about whether chiropractic care counts or whether other treatments count.

Senator CHAFEE. Of course you do.

Mr. GRAETZ. And although the pressures will be smaller to some extent, they are going to be the same pressures.

Senator CHAFEE. Sure. I agree with that.

Now, my next question, very brief answers, can you have portability without universal coverage? Everybody is for portability. I have not seen anybody go around with a sign on their chest I am against portability. [Laughter.]

Dr. Holahan?

Dr. HOLAHAN. I do not think so. I have not really thought that through, but I do not see how you can.

Senator CHAFEE. Michael?

Mr. GRAETZ. I think in order to have genuine portability in the sense that people have the same coverage when they change places

of work and places or residence, you have to have some minimal or standard or basic package, call it what you will, a comprehensive package, that people can carry around and can buy wherever they go. So I think that you do need to have universal coverage in some broadly defined sense.

Senator CHAFEE. Dr. Enthoven?

Dr. ENTHOVEN. I think in the system of Breaux-Durenberger health plan purchasing cooperatives you come very close to portability. If you drop out of your employment group, you can go down to the health plan store, otherwise known as the HIPC and sign up for the plan you have been in and that you want to stay in.

Senator CHAFEE. Dr. Butler?

Dr. BUTLER. You have portability if two conditions are satisfied. Number one, individuals own the plans themselves and it is not changed when people move. Number two, if the degree of help they get through tax relief or other subsidies is not related to where they work. In that case you will get portability, which is the case under the Nickles bill.

Senator CHAFEE. I would like now to address, and perhaps Mr. Graetz having been in Treasury can help on this, as you know the plan I am involved with has an individual mandate. One of the problems that is suggested is that the enforcement mechanism of individual mandates is extremely complicated and I do not think anybody is suggesting it cannot be done, but the difficulties are rather severe as opposed to an employer mandate.

What do you think about that? Remembering, and compare it to the employer mandate with only an 80 percent requirement plus a 20 percent, as in the Clinton bill.

Mr. GRAETZ. For people who are hard to enforce a mandate with respect to, the employer mandate does not really save you anything. It is simply employer financing. That is, if you have an employer based system, you have to have along with it an individual mandate. If you take part-time workers, unemployed workers, seasonal help, family members, all of those people have to be tracked and individually mandated, even if you have an employer based system.

So you do not get rid of any of the hard problems of enforcement by having an employer based system. You may get more money into the system. But in terms of enforcing the additional individual payments and enforcing the additional individual mandate, you do not avoid any of the problems.

I do think that there are a variety of ways to enforce an individual mandate. I go through some of them in my written testimony. The expansion of the earned income tax credit, which was a part of the 1993 Budget Act, means that a huge number of people who before would have no contact with the Internal Revenue Service will now be receiving subsidies through the Internal Revenue Service.

That will help a great deal in terms of enforcing a mandate for those people. They will be eligible for health insurance tax credits in the same way they are for earned income tax credits. I also suggest that medical care providers, such as hospitals can play an important role in enforcing this. To the extent that the plan is administered by the States, there are State unemployment offices and

other State offices that are going to be involved. These people are going to be involved anyway.

Senator CHAFEE. I believe my time is up, Mr. Chairman.

I would just like to say one thing to Dr. Enthoven. You said, as I understand it, in defense of the mandatory alliances or a mandatory alliance, that somebody has to do the certification of the plans. I think that is perfectly proper to be left with the States, with the Insurance Commissioners of the States, just as is done now. They certify whether somebody can sell insurance in their State.

I think that having the massive all powerful alliance, giving it that additional power is, I find, objectionable.

Dr. ENTHOVEN. Well, as you know, I am strongly opposed to the idea of the massive all-inclusive alliance. We think this idea ought to be limited to individuals and small groups up to 100. But there are a number of functions that either they would perform or the State would have to perform including, for example, enforcing community rating and risk adjustment.

Senator CHAFEE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Could I just say, we work hard on lexicon problems around here. I want to thank the Jackson Hole Group because you came up with HIPC, which was retranslated alliance by the administration. No one understood HIPC and certainly no one understood alliance, but health plan store is a very easily understood idea.

Dr. ENTHOVEN. Mr. Chairman, when people say, what is the need for this, I am struggling hard to make a competitive market work here. Some say,why do you need this health plan store and I say, imagine that we had a system for trading securities in which if I wanted to buy or sell the stock of a publicly-held company I had to go to the corporate headquarters of that company and negotiate a deal with them.

So I fly to Detroit to sell some GM and I fly to Palo Alto to buy some Hewlett Packard. Then somebody comes along and says, gee, why do we not have a stock exchange where we bring them all together and we try to perfect the market.

Part of the HIPC idea is the same thing, where as we have in CalPERS or at Stanford in a large employment group, you have an annual enrollment where you bring them all together side-by-side. It is easy for people to make comparisons and they can take their pick and then they are in it. So it is an effort to perfect the market, to the administrative costs to improve people's ability to make choices, simplify choices and so forth.

The CHAIRMAN. And simplified language, for which we thank you.

Dr. ENTHOVEN. Right.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman. This whole discussion we had here this morning, that is this topic of individual and/or employer mandates assumes that we are not even going to talk, say, about single payer. Well, let me be just a bit politically incorrect here and examine that assumption and then go back to where we are now.

I think it is clear that in this room everybody assumes that single payer is not a viable alternative. We are therefore, forced into this discussion of employer versus individual mandates.

But, Dr. Enthoven, you said one of the reasons you did not like single payer is because politically Congress could not resist the requests from various interest groups. Let us assume that that was taken care of. That is, let us assume, for the sake of argument, that there is some kind of Federal Reserve Board which isolated Congress from these demands.

Given that assumption, do you have other problems with the single payer system.

Dr. ENTHOVEN. Yes, I do, but I have a terrible time with your assumption, Senator.

Senator BAUCUS. You have to work with me.

Dr. ENTHOVEN. As you know, I spent the 1960's as point man for Robert McNamara in trying to bring cost effectiveness to the Pentagon. What I learned is the ideal weapon system is built in 435 congressional Districts and it is not very important whether it works or not. So I just cannot easily swallow it, but let me go on.

Senator BAUCUS. On that point though, we did solve that problem with BCRC, with the Base Closing Realignment Commission. That is, we set up a system to insulate the Commission from political pressure and it is working.

Dr. ENTHOVEN. All right.

Senator BAUCUS. It is working.

Dr. ENTHOVEN. Well, I will swallow the assumption to go on with your question.

Senator BAUCUS. All right.

Dr. ENTHOVEN. In my view and personal experience, both in government and in industry, government is a particularly ineffective, inefficient, incompetent purchaser. In part because civil servants are not allowed to use judgment.

So let me contrast what happened in the Defense Department versus my experience when I was President of Litton Medical Products dealing in the private market. In the Defense Department you have to specify the product in great detail and then you put it out there and you have to go with the low bidder.

And in many cases what you get is a defective product. In fact, I had Defense contractors say to me, privately over lunch, yes, we even designed some defects into the product so it would have to come back and be retrofitted and we would have to renegotiate the contract and so forth.

Senator BAUCUS. I only have three minutes left.

The CHAIRMAN. No, you have more.

Dr. ENTHOVEN. But on the other hand, I found when I was in private business, let us say one of my suppliers shipped me a part that did not work in the X-ray machine that I was trying to put together. Now if I called him up and he said, well, Alain, must pay us because we have met the specifications of the contract, I would say, no, no, no. What we are talking about is whether we go on doing business or not.

And if you do not get in here and fix the part so it works in my machine, then I am not going to do business with you anymore. So I was allowed to use judgment, which the civil servants are not al-

lowed to use. If the thing meets the contract specs, then government must pay for it, even if it doesn't work.

So we have doctors who do visits and procedures that are unnecessary, inappropriate that meet the contract specs for Medicare but violate good judgment. The private sector purchaser, can use judgment and that is terribly important.

Senator BAUCUS. Yes, I do not want to debate single payer because frankly I do not think it is in the cards anyway. But you can fashion a single payer with global budgets to minimize dramatically the individual bureaucratic decisions that you are talking about. That can be dealt with.

Let me change subjects here because I do think the assumption here is there will be no single payer.

Dr. ENTHOVEN. All right. Good.

Senator BAUCUS. But if we did have single payer though we would not have to discuss this complexity of employer mandates versus individual mandates; whether there is full coverage or not.

I mean, I think Senator Chafee made a good point on how complex the employer mandate, or the individual mandate, or some combination are. I think it is true, as Mr. Graetz pointed out, that an employer is going to be tempted to game the system.

He is going to be thinking of all kinds of ways, with part-time hires and all the reasons that Mr. Graetz stated. And also, as Dr. Holahan pointed out, the individual mandate is going to be extremely complex, too.

Earned income tax credit today, for example, reaches only 80 percent of people; 20 percent of the people who are qualified do not even apply. As the EITC goes up, there is going to be even more fraud. They are going to try to game the system that way.

And it is going to be very complex. Then it raises questions of, is Congress going to fully fund the subsidy on the individual side, let alone the complexity. So what I would like to do is go down the table here, forget the specifics that apply to employer mandate versus individual, and just give us what you think the one or two basic principles would be that we should follow as we in the Congress attempt to try to decide the degree to which you have an employer mandate, and/or, individual mandate.

What are the basic one or two principles that we should keep in mind as we try to answer this question which essentially Senator Dole asked—where are the votes? So what are the principles that we should follow as we try to find the votes? I will start with you, Dr. Holahan, very quickly.

Dr. HOLAHAN. I guess I think that the one thing is that building upon the employer based system requires less change than other alternatives. That is probably its main advantage. I would also urge you to think about keeping a substantial role for both individuals and employers, such as a 50/50 share of the costs or something like it.

I think as you go in year after year worrying about the costs of the system to have both individual Americans and employers supporting you and your efforts to contain costs.

Senator BAUCUS. So complexity is one factor, as we want something that is not necessarily complex.

Dr. HOLAHAN. Complexity and having everyone have a financial stake in how well this works.

Senator BAUCUS. And a stake. OK.

Mr. Graetz?

Mr. GRAETZ. Well, frankly, I think you ought to try not to hide costs. One of the big problems with the existing system is that people are spending huge amounts of money that they never see. So they do not have to make decisions about buying insurance.

And also, I think you ought to keep in mind that the workers are going to pay the costs whether the employer writes the check or whether the worker writes the check. It is crucial that the worker understand what his health insurance or her health insurance is costing and can take costs into account in making judgments about what to buy.

Senator BAUCUS. You want transparency. There are no hidden costs.

Mr. GRAETZ. Transparency and portability.

The CHAIRMAN. Transparency, nice term.

Senator BAUCUS. Okay. Dr. Enthoven?

Dr. ENTHOVEN. I would say first that we ought to get to work on expanding subsidies for low income people while assuring access to care through a reformed competitive market in which they are guaranteed the option to buy it.

Second, as we progress down that path, we could decide in several years what to do about mandating as we understand better what the source of the problem is, who is it that is not covered and why. Because if it turns out the people who are not covered are people who do not have jobs, then laying on an employer mandate is not going to help that.

Senator BAUCUS. So the basic principles again are what?

Dr. ENTHOVEN. Expand subsidies and reform the system now.

Senator BAUCUS. What do you mean reform? That is what we are trying to do here.

Dr. ENTHOVEN. Yes. Well, by health plan purchasing cooperatives, by standard benefit package, by accountable health plans, and get the competitive reform of the system going. Then I think you could decide in several years with more knowledge about where the problem is, who is it that is not insured and probably you would adopt a hybrid individual employer mandate at that time.

Senator BAUCUS. Okay. Dr. Butler?

Dr. BUTLER. Number one, there must be transparency so people know exactly what the costs are.

The CHAIRMAN. Transparency, good word.

Dr. BUTLER. Number two, individuals and families must own the plan and control the dollars, so the system works for them rather than for an employer or some other group.

Number three, the subsidies to people must be unrelated to where they work. Number four, there must be a maintenance of effort by employers. If they are currently providing assistance, thereafter any change to an individual system the employer must continue to provide that compensation in some other form and cash to the individual.

Senator BAUCUS. thank you.

Senator PACKWOOD. For how long?

Dr. BUTLER. For as long as they are under any contract or certainly for any transition period.

Senator BAUCUS. Does that not become a hybrid then?

Dr. BUTLER. No, it just means the employer does not get to make out like a bandit if the employee is required to pick up the plan.

Senator BAUCUS. I am reminded, being on this committee, tax legislation, we are always trying to find this balance between simplicity and equity. We are faced with the same problem here, between simplicity and equity and it just is not that simple.

Dr. BUTLER. And also between freedom and simplicity.

Senator BAUCUS. Well, that too. From your perspective, that is true.

Thank you very much.

The CHAIRMAN. Thank you, Senator Baucus.

Senator Breaux, we have been hearing a lot about you and Senator Durenberger today.

Senator BREAUX. Thank you, Mr. Chairman. I want to thank all the members of the panel. I would want to acknowledge, as I think is important to do, the good work that Dr. Enthoven has done with the Jackson Hole Group.

Dr. Ellwood was here last week and I think it is very important to know that these gentlemen have really devoted a life time to trying to come up with a solution to the health care crisis in this country.

You know, I think that the congressional clock is ticking on the time that we have to come up with a plan. Spring is very near. I think right now it is clear that none of the plans that have been offered in the House or the Senate right now have a majority to pass, probably not even in the committees that they are being held in.

It is getting close to the time that we really have to sit down and start seeing what Congress is capable of doing in the next couple of months. I would like to ask the panels to comment on this proposition. What kind of a plan would we have with regard to bringing about universal coverage and getting a handle on controlling costs if we passed a plan that had insurance reform of the type we have been talking about, if we set up purchasing cooperatives, if we have tax deductibility for both individuals and for the self-employed, and also finally provide a reasonable set of subsidies for poor people to be able to buy insurance, and finally have a comprehensive standardized plan as part of that package, how do the members of this panel feel that would address the key issues of universal coverage and doing something about the cost of health care?

Dr. Enthoven, since I mentioned your name, do you want to start?

Dr. ENTHOVEN. Well, I think that would be a very large step forward. By insurance reform I am sure you mean guaranteed issue, no preexisting conditions.

Senator BREAUX. Portability.

Dr. ENTHOVEN. Portability and so forth. And I see the purchasing cooperative as being the institutional vehicle by which you institutionalize those reforms so that you do have the health insurance store where you can go in and buy.

I think that would open up a very large part of the market that is now in failure, the small employment group market, and the individual market, it would open that up into a competitive system in which efficient health plans would make large inroads.

I think a limit on tax deductibility that is equitably applied both to the auto worker in Detroit and to the dirt farmer in Arkansas, that is, you get a limited amount tax free, would reform incentives and greatly improve the equity.

I think subsidies for the poor have to be our first priority. We have to protect the poor in this system. And a comprehensive standardized plan I think not only works against risk selection, but it also works against market segmentation and it also provides a format in which we can have some kind of collective decisionmaking about very costly, complex technologies that have to be decided on some authoritative basis.

Senator BREAUX. Mr. Graetz?

Mr. GRAETZ. Senator Breaux, I would agree with Dr. Enthoven that is a major step forward. But as I sit here I am thinking about the historic opportunity that would be squandered if that is all the Congress could manage to do. I was thinking about Social Security and thinking about the discussion that must have happened in the 1930's as to whether individuals should be required to have Social Security or whether it should be a voluntary system providing opportunities for them to go into it.

Frankly, I think we would not have the kind of income security for the elderly that we have managed to achieve through Social Security had they taken only a voluntary step. So while I am sympathetic with you and Mr. Cooper and Senator Durenberger and Alain Enthoven, I do think it is really worth trying to push ahead to put in place a mandatory individually based system that would guarantee health security into the 21st Century.

So while your plan is a very positive step, my answer is tinged with some regret.

Senator BREAUX. Dr. Butler?

Dr. BUTLER. I would say that you would be moving broadly in the right direction with some of these items at least. Insurance reform that limits the underwriting principles and prohibits health status being considered would certainly be a major reform that would be very popular in the country.

I think second you would want to facilitate large purchasing groups. I think you should not overlook that there are large organizations already in existence that would be very sensible vehicles for people to obtain coverage, such as unions, churches, farm bureaus and so forth, rather than limiting yourself only to groups of employers if you want to get to any tax relief.

The third point about tax deductibility being generally available, I certainly agree with that. You do have a budget problem if you leave the form of tax relief simply a deduction and also you do not give much help to those who are low paid.

I think that subsidies are very important for the low paid and should not be related to their place of work. And as I have said before, I do not believe that a comprehensive standardized benefits package is necessary. That would certainly raise costs for every-

body, including the government, but a minimum package is necessary and could be done, I believe.

Senator BREAUX. Dr. Holahan?

Dr. HOLAHAN. I think that everything you proposed would be a major step forward. I guess the things I would worry about is with respect to all the insurance reform outside of large alliances how is that enforced—the community rating, risk adjusting and so forth.

Second, would subsidies be enough to reduce the large number of uninsured people in this country? Probably not. There would still be a lot of people without insurance who would be free riders showing up at hospitals for care when they needed it.

And would costs be controlled in that kind of a system? I do not know. Managed competition might work, but I do not think we know whether it will. I am not sure that I like premium caps very much. I think I might prefer to see something like Michael Graetz's approach to have a Medicare type fall back system that the Congress would control the rate of growth of, that people could go into if the private sector was really not keeping its costs down.

Having said that, I still think what you are talking about is a major step forward.

Dr. ENTHOVEN. Let me just add that I do think over a period of several years that it would be appropriate for the Congress to commit to having a mandate. I mean, we gave to cap this off eventually by saying now everybody has got to be in.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Grassley, you are technically next, but we have already recognized Senator Daschle.

Senator DASCHLE. No, that is fine.

The CHAIRMAN. You are next, Senator Grassley.

Senator GRASSLEY. Thank you, Senator Daschle.

I think I want to talk about managed care plans and I ask Dr. Butler, there has been some concern about these under serving or at least having an incentive to under serve. Karen Davis and Stuart Altmann expressed such concerns before this committee. Do you believe that such plans would have such an incentive?

Dr. BUTLER. I think it depends who they ultimately work for. If they work for health alliances under the Clinton plan, where there are strong pressures on them to—in fact, legal requirements to keep their premiums below a certain level and to cut their budget—they have an enormous incentive to find ways of reducing the level of care.

On the other hand, if they work directly for individuals then you have the ultimate sanction that the buyer does not have to continue buying your product and there would be far less incentive for cutting corners or reducing quality in that case. So I think the ultimate question is: Who does the managed care plan work for?

Senator GRASSLEY. Well, advocates of managed competition argue that the competition would work to offset these tendencies. They argue that, for instance, risk adjustment and quality measurement will work well and they would offset those tendencies.

What would be your views on those and other ways of offsetting the tendencies to under serve?

Dr. BUTLER. Well, I suppose you can to some extent do such offsetting. For example, if you do have a plan that has a disproportionate number of sicker people within it, then a risk adjuster could help offset that and, therefore, reduce that concern if it is really a problem.

But still, to get back to my first point, I think ultimately it does depend on who these plans actually work for. That is true whether it be competition in health care or buying a car or any major product.

Senator GRASSLEY. If individual consumers are paying directly for their health care services, could not consumers enroll in managed care plans if they wished or could not consumer groups, for instance, organize their own managed care plans or could they hire third party administrators who would have to work for the consumer and have the consumer first in line?

Dr. BUTLER. Yes, they certainly could.

Senator GRASSLEY. All of those?

Dr. BUTLER. I think that would probably tend to happen. If you look at the Federal employee system, for example, where individual staff members and members of Congress can pick different plans, there is a higher proportion of enrollees in managed care in that system than is true in the country generally. Many of those plans are offered through employee organizations, whether it be Capitol Hill Staff or the Mailhandlers Union or whatever.

So I think individuals picking plans does not mean them always picking fee-for-service by any means. But the ultimate point is that they will pick the plan that they feel serves them best in terms of value for money. If it happens to be managed care, that is fine. If they think they are not getting a good deal in terms of quality of service, they will go somewhere else.

Senator GRASSLEY. Would not making it possible for consumers to pay directly for health insurance or health care give consumers, and sort of consumer grouping you might have, more power in the system relative to managed care companies and insurers?

Dr. BUTLER. Yes, I do not think there is any question about that. And if the group that you are talking about is a group formed by the buyers themselves—and this is why I raised such examples as union plans—so it reflects the members themselves rather than some artificial creation, such as a HIPPC then that organization is going to be much more responsive to the individual members and is going to be more effective accordingly.

So with these intermediate groups, again it depends who they ultimately represent. If they come from the buyers themselves they will certainly work on their behalf. If they are some artificial creation, there is no guarantee that they will work on behalf of the individual enrollees.

Senator GRASSLEY. Then let us extend this point directly to the Nickles plan in this connection. Is there any reason that managed care plans could not flourish in the marketplace were the Nickles plan enacted? And also, would not such plans give more power to consumers relative to managed care companies and insurers?

Dr. BUTLER. I think they certainly would flourish. Again, just look at the Federal employee system. There you have a case where people can pick the combination of quality, and price, and form of

service that is right for them. There is a much higher incidence of buying managed care.

I think that would tend to happen. That is not necessarily to say that in 20 years time you may not get a totally different structure of delivery. But if it did change over time, it would be a result of individuals deciding on a different form of delivery of health care. I think that is the crucial point.

So I think managed care can and would flourish under an individual-based system and it would do so because people chose that form of delivery.

Senator GRASSLEY. 1 have a question about an estimate you made for the Nickles bill. You estimated that it would lead to a small cumulative surplus in the Federal budget over the next 5 years.

Then there was a Lewin study that states that the Nickles plan would yield a $9 billion greater deficit than the Clinton plan in 1980. Have you tried to reconcile these what are seemingly conflicts?

Dr. BUTLER. Both of those, for Nickles and for Clinton, are snapshot figures for 1 year. In the case of the Clinton plan, Lewin-VHI estimates, I believe, that there would be a net budget surplus over the 5 years. And if you look at the CBO estimates of the likely growth in cost of a tax credit, based on how much is spent and on the exclusion, and other features of the Nickles bill, it is on that basis over the five-year period that we estimate it would come out over the small surplus.

Senator GRASSLEY. Mr. Chairman, I am done. But I think Dr. Enthoven had something he wanted to say about a previous question.

The CHAIRMAN. Sure. Of course.

Dr. ENTHOVEN. I would just like to offer a comment about the use of the Federal Employees Health Benefits Program as a model. And again, I have to plead guilty to learning.

Back in the 1970's when I first wrote Consumer Choice Health Plan, which I proposed for the Carter Administration and published in the New England Journal of Medicine, I did use the Federal Employees Health Benefit Program as a good example of a multiple choice competitive system at a time when people were saying competition and multiple choice is just not possible in health care.

But then over the years as I studied it more closely, what I found is that for example they have nonstandard benefits. Every plan conjures up its own benefit package. That leads to serious problems of risk selection, indeed spirals of adverse selection as, for example, the Aetna had to withdraw because they got a lot of bad risks and the Blue Cross and Blue Shield plan drew a lot of adverse selection. So you have a competition based on risk selection.

The CHAIRMAN. That occurring because you do not have a standard benefits package.

Dr. BUTLER. And you have community rating.

Dr. ENTHOVEN. Also, you get market segmentation which mitigates against competition. That is, Plan A offers wonderful vision care and no podiatry. Plan B offers wonderful podiatry and no vision care. OK? All the people with bad feet and good eyes, they

want to join Plan B. But all the people with good feet and bad eyes they join Plan A.

What I am proposing and urging here is we create a market in which if Plan A raises its price by $10 a month relative to Plan B, that lots of people desert Plan A and rush to Plan B to punish Plan A for raising its price. And the trouble is, to the extent that you have the market segmented like that, then people do not move.

In the Federal employees plan we have this book that comes out that tries to explain all that to people. I used to be a Federal employee myself. I saw what my fellow employees did and that everyone looks and says, let us see, do I have bad eyes, do I have good feet, do I have this, that and the other thing, and which little niche plan do I fit into best.

And that is anti-competitive. We need to do a much better job of making market forces maximally effective if we want to make this thing work well.

Senator CHAFEE. Is that not adverse selection what you described?

Dr. ENTHOVEN. Yes.

Senator CHAFEE. You had another term for it, some structure.

The CHAIRMAN. Segmentation.

Dr. ENTHOVEN. Segmentation, yes.

Senator CHAFEE. Why does that word work its way in here? Why do we not stick with adverse selection?

Dr. ENTHOVEN. Because there are two problems, Senator. One problem is adverse selection, the good risks and the bad risks. The other problem is what is called segmenting the market. It is something that we teach in business school. That is, if you do not want to compete you find a little niche where nobody else is and you get in there and you make your product and you jack up your price.

And if we as public policy people are trying to make the market competitive, then we want to combat what I call market segmentation. So my example was, Plan A has wonderful vision care and no podiatry; Plan B has wonderful podiatry and no vision care. And that is anti-competitive because those people who have bad eyes and good feet, they do not say am I going to join Plan A or Plan B based on the price and I am going to switch to Plan B and so forth. They just say,this is the plan that covers my problems of bad feet and good eyes or vice versa.

So as I say, what we did in CalPERS, for example, and what we did at Stanford, and at CalPERS it was a brilliant success, we made a decision to say, all of our HMOs are going to offer the same standard package. That makes it easier to choose. That counteracts the idea of segmenting the market.

So the reason competition heated up a whole lot when we did that is people could more easily compare value for money and we are much more willing to switch from Plan A to Plan B if Plan A raised its price relative to Plan B.

There is also one other problem, which is what I refer to as fear of air pockets, which is certainly there in the Federal employees' plan. That is, I am considering switching from Plan A to Plan B to save $20 a month in premium. But what I am afraid of is, maybe in the fine print Plan B has some hidden exclusions that I will discover sometime in the middle of the night, much to my det-

riment, such as organ transplants, not covering harvesting and transporting the organ.

So I am suspicious of that and so I am reluctant to change to Plan B that costs less. What I am trying to do and am recommending to the world is, we try to create a market in which people are very willing to switch from Plan A to Plan B to save $20 a month in order to make it terribly hard on Plan A if its price is too high.

Dr. BUTLER. Senator, what Dr. Enthoven is saying is that the problem with the Federal employee system is that people actually buy the benefits that they want rather than what the insurance company wants to sell them. That is not a particularly terrible problem in my view.

The CHAIRMAN. All right. We will have another round of questioning.

Senator Daschle has been very patient.

Senator DASCHLE. Thank you, Mr. Chairman.

I would only remind my colleagues that we legislated standardization a couple of years ago with Medicare supplemental benefits. We standardized the benefits and it has worked very well. We have had a lot less confusion, a lot less overselling, a lot more competition among the plans.

So I think Dr. Enthoven's explanation is a good one. I must say I respect a lot of what the Jackson Hole Group has done. You just said something, however, to Senator Baucus that I really think we ought to revisit for just a minute.

I am not a single payer advocate either, but I think often times what happens around here is that the more we repeat something the more it becomes conventional wisdom. And right now conventional wisdom seems to be that the government cannot do anything as efficiently as the private sector.

As we analyze health care systems in other countries, the myth is that they do not operate as efficiently as we do. But I hope, Mr. Chairman and members of the committee, we can break through this myth and look in a very analytical way at how other countries run their health systems, how we do it, who does it better, who does not do it as well.

I think if we emphasize facts rather than assertions in our analyses, then we can ultimately make better decisions. I wish, Alain, that your experiences would have shown you the Federal Reserve Board or the Air Traffic Control System, because I think those systems within our government have worked very well.

The Federal Reserve Board does not jack interest rates around at the whim of the economy or of business. The board is an independent entity, making some very tough judgments based upon what it sees happening to the economy. The air traffic control system does not allow American Airlines an unlimited number of slots in Chicago. The traffic control system has to be able to say no.

My point is that, for health care reform, we can devise a good interface between government and the private sector, as we have done with our monetary and our air traffic control systems. My question, however, goes really to a different point, and I would like you to address it if you could.

We have talked about a lot of different mechanisms for financing. But if you stand back and look at all of our options, you really only

have three ways with which to finance our health care system—premiums, taxes and out-of-pocket expenses. I do not know of any other financing sources.

I think the fundamental question that we on the committee have is: How do you determine how large a role each of those sources should have to get the most efficient system? I would like you to respond to that question if you could.

Dr. ENTHOVEN. Should I start?

Senator DASCHLE. Sure.

Dr. ENTHOVEN. Well, I think that for people who are economically self-sufficient it is a good idea that mostly it is done by premiums. So that my health plan knows they are getting money from me because I am a satisfied customer and if they do not keep me satisfied next year, I will switch to somebody else.

I think we need to use taxes in the case of people whose incomes are too low for us to reasonably expect them to pay their premiums. With respect to out-of-pocket expenses, there are two kinds of out-of-pocket expenses. One is, my premium contribution and I believe that is very important. Like what we did at Stanford University is, Stanford said it will contribute 90 percent of the price of the low-priced plan and then the consumer pays the rest.

So if you pick a more expensive health plan you pay the difference and that gives your health plan an incentive to hold the price down.

The other kind of out-of-pocket expenses at the point of service, I think a limited amount of copayments. We use at Stanford $10 when you go to the doctor. That is fine to remind people that this costs money and to not waste it.

However, it is important to recognize the great majority of the costs, like 75 percent of the costs in health care go with the 10 percent of the people who have the highest costs. They have passed any kind of out-of-pocket spending limits.

If we are going to give them reasonable financial protection like saying you are not going to have to spend more than $2,000 a year out-of-pocket, then most of the money is beyond that. So out-of-pocket payments at the point of service I do not think are very effective.

Senator DASCHLE. Dr. Butler?

Dr. BUTLER. Senator, you mentioned the Air Traffic Control System, which has a government budget and is grossly undercapitalized with technology that is years out of date. I think a lot of us have the same worry that that is what would happen in the health area.

Senator DASCHLE. There are 4 million people use that system everyday.

Dr. BUTLER. Oh, yes. I do not disagree with that. But I am just pointing out that is one of our concerns about government control in health in fact is highlighted by that very system.

As far as what are the elements in securing coverage, I think one of the most important things that has got to exist in terms of the balance between premiums and out-of-pocket expenses is that the tax system should be neutral with respect to the decision made by an individual person.

Today we have over-insurance in a great many situations, because if you buy insurance, or at least if your employer buys insurance, it is tax-free without limit. If you decide to buy that $5 prescription yourself, rather than file an insurance claim, it is in after-tax dollars. So there is a powerful incentive with the tax system to get people to over-insure for minor things that they would not rationally do otherwise.

So I think the tax system should be neutral in that respect, and that would deal with a lot of the issue about which is the better and most efficient. The tax system and other forms of subsidies should be used, as others have said, to make sure that lower paid people and people with severe medical problems should at least be able to obtain what we would consider broadly an adequate level of care. And the tax system has a very important role—it is probably the only system that we have as a form of government subsidy to secure that objective.

Senator DASCHLE. Thank you.

Mr. GRAETZ. Senator Daschle, the biggest surprise to me in this health care reform debate has been the desire to continue to rely on out-of-pocket payments. I really do not get it. If you have ever dealt with insurance companies and balanced billing and so forth, I think what you are spending in administrative costs compared to what you are getting in terms of people being attentive to their purchasing of medical services at the point of service is ridiculous.

One of the things we could learn from abroad is that one of the ways to get rid of administrative paperwork burdens that do no good is to get rid of a lot of this out-of-pocket stuff. So I would rely on that virtually not at all.

With respect to the choice between premiums and taxes, it is a choice between premiums, taxes and subsidies. It is clear that you can mess up any combination of those. That is, you can get bad taxes, bad subsidies and so forth.

The point that Alain Enthoven makes, I think, is essentially right, which is that in order to analyze this you should look at individuals and look at individuals based on their income. Premiums are very high as a percentage of income for low income people.

So some portion of their costs needs to be subsidized and financed through the general government, which requires some taxes. I do not think it is terribly helpful to try and call mandatory premiums or mandatory payments something that they are not. We ought to keep in mind the question of fairness and look at the net payment by individuals based on their individual circumstances, based on their income and how much they can afford to pay.

I think that a system which combines taxes and premiums and subsidies can be organized well to serve that purpose if it is done for individuals.

The only other thing I would add is that I think you have to be very careful not to create major disruptions in the marketplace that are unrelated to what you want to accomplish. The problem with the employer mandate is that it reintroduces all of the kinds of disincentives and strangeness in terms of allocation and hiring of workers.

Much of the effort of this committee in tax reform in 1986 was designed to get the government out of these decisions. I think that we ought to remember that as well.

Senator DASCHLE. I am out of time but, Dr. Holahan, I would appreciate your comments.

Dr. HOLAHAN. I think you would begin with premiums and then the issue is the share between employers and individuals. You have to subsidize individuals and then that is where the taxes come in.

I think that is a real serious issue here under an individual mandate or even a combined mandate. The amount of money that people would be paying at 250 percent of poverty can be fairly high relative to income.

If you were to seriously address these burdens, it is going to mean more in taxes. So that trade off between how much you want to subsidize people and how slowly you want to phase out those subsidies as income goes up has direct implications for how much new tax dollars have to go into the system.

Senator DASCHLE. Thank you very much.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

I would like to hear from all of the panel participants an answer to really two questions. One, if you were to summarize what are the most important message you would want to leave this panel with today, number one. Number two, what have you heard today that you would want to warn us against?

If we could just go down the panel. What is really the heart of the message you would want to leave us with today? And number two, what have you heard from another panel member, perhaps a member of the Finance Committee, that you would want to warn us against? Dr. Butler?

Dr. BUTLER. If I can take the first crack, I think what I would like to leave you with is the notion that an employer mandate is not a free lunch for the employee, that is in fact a disguised cost for the employee and that you must take that into account when you look at what the impact of any plan is going to be.

As I have tried to point out, a tax credit approach on individuals ends up with a better result.

The second point you asked, in terms of what we are most concerned about, I think it is maybe two things. One is the mistaken notion of a standardized benefits package being the only way to somehow secure adequate services for people. I think that is profoundly wrong and has many, many problems, including costs associated with it.

Senator CONRAD. All right. Dr. Enthoven?

Dr. ENTHOVEN. Well, I would say the most important message is, we must get the incentives right. We have to create a system in which everyone has incentives for economical behavior. And the biggest and most important place to start with that is on a limit on tax-free employer contributions so that the person who chooses the more expensive plan pays 100 cents on the dollar for that choice.

The CHAIRMAN. If I could interrupt, your testimony says, "the uncapped tax break is a bleeding artery in the Federal budget."

Dr. ENTHOVEN. That is right, Senator. It is projected for 1995 at $90 billion a year. I mean, this, if I can paraphrase Senator Everett McKinley Dirksen, $90 billion and $90 billion there and after a while it begins to add up to real money.

With respect to what I have heard today, I would warn against the idea that market reform is easier than it is. I think that a reformed market has to be structured with care. I think there are problems like risk selection that slosh through this whole thing.

You know, a free market in health insurance would produce intolerable results because insurers would be very clever about covering the people who do not need medical care and avoiding the people who do. They would confuse the customers and do all kinds of bad things that we have been seeing for a long time.

So market reform requires a lot of care and I think it includes, you know, a sponsor, a single point of entry as in a purchasing cooperative, standardized benefits and so forth.

The other thing that I heard today which reflects my own growing development and point of view is the employer mandate does have a lot of problems.

Senator CONRAD. All right. Mr. Graetz?

Mr. GRAETZ. Well, Senator Conrad, I agree with my colleagues that the one thing I think should be avoided is the employer mandate. There are lots of difficulties with the employer mandate that have not been discussed. Let me just name two.

One is that the Clinton proposal has in it a nondiscrimination requirement that bars employers from discriminating based on family status. It turns out to be essential if you have an employer mandate to have that kind of nondiscrimination rule in it.

Second, it fails to distinguish independent contractors from employees. That is a problem that this committee and the other tax committee in the House and the IRS have struggled with for 25 years and not solved. And we are not going to solve it in this health care debate.

So while individual mandates have problems, so do employer mandates. If I were to say what I would warn the committee against, it is in some ways a reflection of what I have heard her today and what I learned when I was here for two-and-a-half years just recently: that the fear of taking some short-term pain has the potential to bar a lot of long-term gain. I really would urge this committee and the Congress to a take a little longer term view about this problem and ask where is it that you really want to be after we go through this exercise.

Because I dare say as painful as this exercise is going to be for this committee and for other committees on both sides of the Capitol, this is going to be the last time in a long time that you are going to have an opportunity to do a major health reform. I would urge you to take a long-term view.

Dr. HOLAHAN. I would say, number one, that I think the idea of a mandate of some sort is essential. I think both individual and employer mandates have problems, not just employer mandates. As you think seriously about the possibility of an individual mandate which I would not argue with anybody does have an awful lot of attractive features, these problems will be more evident. For example, the costs of funding a set of subsidies to make sure that peo-

ple's out-of-pocket expenses are kept at a reasonable level relative to income, can be very expensive, particularly if a lot of employers drop coverage.

I think you need to look at the simulation analyses that a lot of people are capable of doing under both the assumptions that employers drop and that they do not and see what you think about those estimates.

The CHAIRMAN. Thank you, Senator Conrad.

I would just make the note, because Dr. Enthoven did not read it in his oral testimony, the written testimony says, "As the congressional Budget Office all but said the Clinton employer mandate is a tax."

One of the questions this committee has to ask is, do we tax directly or do we do the same thing without quite owning up to it.

Dr. ENTHOVEN. May I just offer a brief comment on that? That is, one of my sons is working in a small start-up company in the Silicon Valley and his pay is now in the low $30's. He is a few years out of college. Once we were talking it over with him and also talking it over with a secretary whose pay is in the low $30's we discovered that they are effectively now in the 50 percent marginal tax bracket when you combine income taxes, payroll taxes, State income taxes and so forth.

What I am concerned about, my enthusiasm for payroll taxes as in the Clinton plan is attenuated by the fear that this 7.9 percent is going to grow up into something like 12 percent and that these people are going to find themselves in a Scandinavian-type of marginal tax bracket. I see that as a real problem.

The CHAIRMAN. Well, no one knows more about that subject on this committee than the Senator from New Jersey. Senator Bradley?

Senator BRADLEY. I have never been to Scandinavia. [Laughter.]

Dr. ENTHOVEN. But you have been in New Jersey.

Senator BRADLEY. Right.

Let me ask you, Dr. Enthoven, I would like to ask each of the panel members, give me the two biggest disadvantages of employer mandates and the two biggest disadvantages of individual mandates from your perspective.

Dr. ENTHOVEN. Well, the biggest disadvantage of the employer mandate is that it is based on the myth of employer paid health insurance, which is really a myth. That is, the costs do fall back on the employee. Therefore, costs are shifted to employees which is OK if they are not poor. It is also a big increase in the minimum wage and it is costly to enforce. And experience in Hawaii shows it does not get the job done necessarily.

Big disadvantages of individual mandate. I am not impressed by any major disadvantages at this point, except for the problem that I do believe somehow it is important to keep employers in the game as an alternative to government to provide the group basis for health insurance.

That is, I do not think it would be a good thing to have a Clinton type alliance in which all health care is purchased through a government agency, both because of the temptations to make that the super regulator would be irresistible as the first draft of the Clin-

ton plan did, and second, I think it is a big step toward a single payer.

So I do strongly believe in pluralism on the demand side and combined with the need to have a group basis for health insurance.

Senator BRADLEY. Dr. Butler?

Dr. BUTLER. Well, I would agree with Dr. Enthoven. Certainly the myth of the employer mandate as a freebie for employees, is one of its biggest concerns, both in terms of hidden costs and also the tendency of employees to demand excess insurance as we know well today.

The second problem I think is the issue of job losses and job churning, the enormous incentives on employers to fire certain people who would pose large costs, or moving them from full-time to part-time. All these things are inevitable problems.

I also agree with Professor Enthoven that I cannot think of too many serious problems with the individual mandate as an alternative to that. It is very explicit. It is very clear. I think there are ways of working through employers to at least assure compliance as well as through the Tax Code. And I do not think compliance is any bigger problem, quite frankly, under an individual mandate than under an employer mandate.

Senator BRADLEY. Under individual mandate the initiative lies where? Who takes the initiative for the individual to get covered?

Mr. GRAETZ. I would think, Senator Bradley that you would couple an individual mandate with a payroll deduction requirement, a withholding requirement, so that for the people who are working it would appear very much the same way to them as a employer mandate, except that you could target your subsidies and government money a lot better and eliminate the disincentives in the work place.

But it would look pretty much the same to workers through employment because it would be a deduction from wages. And for the nonworking people you are going to have to enforce an individual mandate anyway.

I do want to repeat something I have said before while you were away. That is that this is not a choice between an individual mandate and an employer mandate. It is a choice between an individual mandate and both an employer mandate and an individual mandate. The employer mandate does not eliminate the need to track individuals who have part-time work, who are unemployed, who are children, who are in and out of the work force. All of the people for whom there are serious administrative problems of enforcement of any law are going to be difficult here—those solutions do not appear by having an employer mandate.

To the extent that you want to achieve the administrative advantages of an employer mandate, you can get those through payroll deductions and withholding. So I think that that is basically it.

With response to your question, I think the worst problem with an employer mandate and subsidies that are employer based—and it is the combination of mandates and subsidies because you will inevitably subsidize businesses that you are concerned about during the short term with an employer mandate—is that they create very crazy incentives in the labor market which one could list. There must be 20 of them I could list for you.

Senator BRADLEY. Okay. Quickly with Dr. Butler. You have this innovative idea about eliminating the tax subsidy and turning it into a refundable tax credit. Would you take the entire $40 plus billion and shift it into a refundable tax credit?

The CHAIRMAN. $90 billion.

Dr. BUTLER. I would and the Nickles legislation specifically does that. It just gives tax relief to the individual in a different form, a refundable tax credit rather than——

Senator BRADLEY. It would take the same amount of money?

Dr. BUTLER. Absolutely.

Senator BRADLEY. Would this result in essentially a tax increase for well to do, upper income individuals?

Dr. BUTLER. It would be a slight increase at the very upper income levels, although the way the Nickles bill is structured there is an added degree of subsidy to fund the tax credit that comes from modest reductions in Medicare and Medicaid so that, in fact, there would not be any increase except for very, very highly paid people.

But the middle class would come out ahead in terms of tax relief under the way the Nickles bill is structured.

Senator BRADLEY. Wait a minute. There would be no decrease in what for the vast majority of people? Would you have a refundable tax credit going from 25 to 75 percent, 75 percent at the low end, right, or depending on who uses the health care system?

Dr. BUTLER. That is correct. Most people would be on 25.

Senator BRADLEY. Most people would be on 25?

Dr. BUTLER. Most people.

Senator BRADLEY. So what you are saying is everybody who is out there now getting essentially a $5,000 or $6,000 value nontaxable every year would not end up paying more taxes?

Dr. BUTLER. When Lewin-VHI analyzed the Nickles bill, they estimated this and it is in the complete study that was mailed over to you. Essentially the crossover point at which people would end up losing more from the abandonment of the exclusion than they gained from the credit is at around $75,000 on average.

Below that they would be ahead by varying degrees. The lower their income the more they would be ahead compared with the current system.

Senator BRADLEY. Mr. Chairman, may I ask another one?

The CHAIRMAN. Please.

Senator BRADLEY. Let me ask Mr. Graetz—and if other members of the panel want to comment on this, I would appreciate it—you really came at the employer based subsidies and you raised the question of the caps of a percent of payroll and so forth and other unintended results.

My question to the panel is, if you have one cap for a larger company and a different cap for a smaller company, is there any incentive for big companies to become small companies and/or part-time. And if big companies become small companies or small companies lay people off who become part-time, what happens to the pension benefits that they have accrued when they were with the bigger company?

Might we be having an unintended consequence here of assuring everybody has health care, but at the same time jeopardizing some of their pension benefits? Now what is your comment?

Mr. GRAETZ. Senator Bradley, there clearly are incentives to reorganize businesses and to reorganize your labor force with an employer mandate. A business may want to put all of its high paid people in one organization so that they are subject to the premium amount as a cap rather than the percentage of payroll amount and then put low-income people in a plan where they are subject to the payroll amount as a cap.

The CHAIRMAN. We will catch you with that.

Mr. GRAETZ. With all due respect, Senator, having worked with the tax system for 25 years now——

The CHAIRMAN. We will not?

Mr. GRAETZ.—I fear that you will not catch as many people as you would like to catch. So there clearly are incentives for reorganizing businesses, for segmenting labor forces, and for hiring people who are in different circumstances and for using—and I think this is an important point related to your pension point—for using temporary and seasonal help and overtime so that you do not even allow people to enter into the labor force who might get pension benefits. You are coupling your health incentives with your pension costs there. So I think there is a risk.

And to the extent that whether the people are in and out of the work force—women, low-income workers and so forth—those pension benefits are far less secure already than people believe them to be. You may be adding an additional element of insecurity. I think it is an important concern, and, frankly, not one that I have heard before.

Dr. ENTHOVEN. A couple of comments. For example, in the Clinton plan where they propose to limit employer contributions to 7.9 percent of payroll. I think the first thing that does is that it kills the incentive for employers to innovate the control cost. In fact——

The CHAIRMAN. Once past 7.9.

Dr. ENTHOVEN. Forget it.

The CHAIRMAN. And, of course, there are 6 different rates, 5 of which are less than 7.9.

Dr. ENTHOVEN. And if you look back at what has happened in the last 15 years, there has been tremendous innovation in the private sector with the growth of HMOs and multiple kinds of HMO's and the growth of preferred provider insurance and employers have been very active and creative in promoting innovation.

Meanwhile, good old Medicare rocks along with its same obsolete fee-for-service, solo practice, remote third party payment model frozen in time in the 1960's. So I think that that cap it wipes off the battle field the institution in America that is most interested in controlling costs, the employer. That is problem one.

Problem two is in that 7.9 percent cap I see a huge risk to the Federal budget that the revenues are tied to wages. Now if health care costs continue to rise faster than wages as they have been doing in this country for at least 50 years we know about, as well as in Canada, et cetera.

The CHAIRMAN. Fifty, 5–0?

Dr. ENTHOVEN. Yes. I am picking a number out of the air. Then the problem is, the Federal budget is at risk. Now I did a simplistic calculation some time ago based on the numbers out of the Clinton plan and said if you project Federal costs forward under the Clinton unrealistic goals of 1.5 percent real increase per capita in 1996, one in 1997, one-half in 1998 and zero real per capita in 1999, projected forward that way, then instead make an alternative projection which is like Canada.

In Canada from 1985 to 1990 real per capita spending grew 3.5 percent a year.

Senator BRADLEY. Right.

Dr. ENTHOVEN. If we had a Canadian style health care cost growth it would be something like $160 billion a year more in the Federal deficit. So I think that is another major unintended consequence, because I, frankly, really have my doubts that with these Clinton price controls on premiums that when we start seeing people queuing up denied service, doctors laid off, hospitals closed and so forth, I just have my doubts that the legislature will be able to hold the course on that.

Senator BRADLEY. And on the pension point?

Dr. ENTHOVEN. That sounds like a reasonable point. I just had not thought about it.

By the way, we certainly ought to have individual portability for pensions, you know, just like professors have through TIAA, CREF and so forth. There ought to be a system for everybody where your pensions are portable and stay with you.

Senator BRADLEY. The only difference there, not to belabor the point, is that the auto worker does not have tenure.

Dr. ENTHOVEN. All the more reason that his pension ought to be portable.

Senator BRADLEY. Right. Dr. Butler?

Dr. BUTLER. I do not really have anything to add to the others. I think you are correct that any mandate system with even a subsidy would jeopardize pension programs and other benefits by causing churning of the labor force, by a disinclination to hire people on a longer term basis and so forth.

Exactly what the figures would be, I could not comment. But there is no question that you would see a drift toward short-term people, seasonal people, part-time workers, and all these people would be less likely to be included under pension benefits. And if there is any churning of labor, releasing full-time people for part-time people then, indeed, their pension benefits would be jeopardized.

Dr. HOLAHAN. I would just add that I think at least some of the problems you have mentioned are inherent in the structure of subsidies that are in the Clinton plan that are not necessary. If you have a smaller employer contribution, I think you get away from a lot of that, including the problem of the 7.9 percent cap that Alain has talked about. You just really do not need that with a smaller employer contribution.

Senator BRADLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bradley.

If I could just say that, if there is one thing I have learned in these hearings, it is that whatever else we do, now that employers

are interested in the costs of health care, keep them interested. Because with all that managerial skill, they do read small print in a way that the individual will not. And you do not ever want to say that you were interested from 1985 to 1995, but you do not have to be interested any longer. That would be the worst idea.

Can I ask Dr. Butler something which is probably being too easy on him, but we are going to have this job summit in Detroit next week, is it possible that some of the slow growth in employment in Europe is associated with the health care provisions? They are not identical, of course—Germany as against France as against Britain.

Dr. BUTLER. You described it as an easy question. Indeed it is, because I think there is no doubt about that. I lived for 30 years in Britain. I am very familiar with the costs associated with a system there.

If you look at the cost of hiring in most of the European countries, it is significantly higher than in this country. Having a mandate on employers such as the Clinton plan would do would mean an increase in the cost of hiring full-time people. I think that without any question this would reduce the rate of growth of employment among the full-time people. There is no question about it.

The CHAIRMAN. Well, I did not want to have the Heritage Foundation come and feel we were not going to be receptive, at least in some respects.

Dr. BUTLER. It is very kind of you to say that, Mr. Chairman.

The CHAIRMAN. And now Senator Roth, to wrap up for the morning. We are getting into the afternoon.

Senator ROTH. Thank you, Mr. Chairman.

I would like to ask some questions in respect to the Federal Employee Health Benefits Program. I know you are all familiar and I realize that some comments have already been made. But this is a program that has worked, it seems to me, very well. Something like 9 million Federal employees, retirees and their dependents are enrolled over 300 participating plans.

So I would like to ask each of the panel these questions, Mr. Chairman. First, would you continue the Federal Employee Health Benefits Program? Under the Clinton plan it, of course, would not be continued.

Second, what I would like to consider is opening that plan particularly to small business and self employed. I would like to get the comments of you gentlemen as to the feasibility of that approach. Now I understand there is some difference of opinion as to whether there should be one standard package and why can we not continue with the present proposal that has, as I say, roughly 300 participating plans.

And finally, I would be interested in knowing how many millions do you think could or what numbers could be covered by opening this plan? How much accessibility is there here?

Dr. ENTHOVEN. Well, would I continue the Federal Employee Health Benefits Program, I think it would be a good idea to continue it. But I do think that the management, the structure has significant defects that ought to be corrected. The first one being we ought to standardize——

The CHAIRMAN. That is segmented.

Dr. ENTHOVEN. Yes, right. That we need to standardize the benefit package, something that is very hard to do politically once the government is controlling it. But we have done that in CalPERS and it has worked very well.

The fact that the employee is cost conscious in his choice is a very good thing about the Federal Employees Health Benefit Plan, but the formula attenuates that to some extent because it only pays 75 percent of your premium for a low-priced plan.

So it ought to be changed so that there is full employee cost consciousness in the choice of plan, that you always save a dollar if you pick a plan that costs a dollar less. I know these sound rather technical but they are really important to get this right, to get the incentives right. So the Federal employee plan does need a tune up.

With respect to opening the plan to small business, right away you are going to hear howls from employee unions I am sure because they are going to be afraid of things like are they going to get adverse selection, are the bad risks going to be dumped on them, are people free to join or not join and so forth.

So I think that is not good enough by itself. I think we have to have large scaled pooled purchasing arrangements which I hope would be pluralistic, but which requite people to join one or another pooled purchasing arrangement so that we do not have risk selection sloshing around and messing this thing up.

With respect to the idea of opening this to the Federal—you know, like, let us call everybody in America a Federal employee for health insurance purchases, frankly, I am much more of a believer in Jeffersonian democracy, in a decentralized world.

I fear that this would become the super Clinton alliance, the Federal Government doing the whole thing. And as much as I admire people who are in the Federal Government, and many of the happiest years of my life were as a civil servant, nevertheless I think it is very bad to concentrate so much power]it in one institution.

I think we ought to have purchasing cooperatives by and for small employers out in local areas. We ought to have public employees in one purchasing pool, Medicare in a different one and so forth, and not put everybody into one massive entity because I think that is an invitation for somebody to make it into a single payer.

Senator ROTH. Dr. Butler?

Dr. BUTLER. Senator Roth, as you know, the public unions in the Federal system are determined one way or the other to keep the current system that they have under the Clinton plan. I think that is very instructive in terms of showing there is good value for money in that system.

In fact, to add to your points, you do have a choice of plan and type of coverage under the Federal employee system. There are very few mandates on what particular benefits have to be in particular plans. I think that is instructive in showing how an individual system would work. Many of the issues and concerns of adverse selection that Professor Enthoven raised could be dealt with quite easily under the Federal employee system by moving toward limited underwriting rather than community rating in the way the premiums are set.

As far as your specific questions, under the Nickles bill the Federal employee system would in effect be continued. The method of subsidy to individual Federal employees would change to a credit rather than the current explicit subsidy and exclusion.

But essentially it would be opened up to everyone. And Federal employees, incidentally, would even have a wider choice if they wished to exercise it under that new system.

Second, as far as opening it to small business and the self-employed I think that is a very useful step. Of course, under the Nickles bill it would be extended even wider in practice. That is what I would prefer, so that your place of employment would not be a limit on your choice.

As to how many people would be included if you did extend it in this way, if you extend it to everybody and require people to join, then everybody would be included. If it is opened to small businesses and the self-employed, I really could not make an estimate off the cuff of how many. It would be a pretty large proportion of the uninsured.

In talking to a number of the companies that provide policies through the Federal employee system I have posed the question, "If all the uninsured were to be included, what impact would it have to you?" They generally say that they feel the premium rates, if anything, would decline, chiefly because although the uninsured are sicker than the equivalent people who are insured, they do tend to be disproportionately younger people.

So it is not clear that including all these people would actually push up the cost for those that are currently insured under the system. So I am not sure the union concern about the impact on premiums is not justified if you actually look at that effect.

Senator ROTH. Mr. Graetz?

Mr. GRAETZ. Senator Roth, I agree basically with what Alain Enthoven has said. I think it is a good plan. Comparisons are difficult now so some standardization of benefits would be a great help, and you have to have risk adjustments across plans, almost no matter what.

I do want to say—Alain has now repeated this two or three times—I want to emphasize that giving people the option to enroll in the Federal employees plan is not putting the Federal Government in the middle of buying insurance for everybody, and I wish that Alain would get CalPERS to let us all enroll in their plan as well. That would be a great advantage.

The CHAIRMAN. That may be the key idea. [Laughter.]

Mr. GRAETZ. If they do as well as Alain claims, we would all go to CalPERS. So the competition with the Federal plan will be based precisely on the price and quality considerations that people who are interested in competition are interested in.

Dr. ENTHOVEN. Michael, I am still in shock from reading the September 7 version of the Clinton plan in which health alliances had every regulatory power imaginable, including the kitchen sink. So I see a framework there that is too—if it is centralized and monolithic that is too easily converted into the regulatory and the single payer.

Mr. GRAETZ. Let us not confuse bad plans and good plans. That is all I can say.

The CHAIRMAN. Dr. Holahan, the last word.

Dr. HOLAHAN. I think I generally agree with what Alain Enthoven has said. I guess I do not see the Federal employees plan as a model because it does not have a lot of insurance reform provisions that are in a lot of the other bills. So I think it would just have a lot of adverse selection problems. It already does.

Senator ROTH. Thank you.

The CHAIRMAN. Thank you, Senator.

Great thanks to our panel. Thanks to Professor Tobin who has contributed to it, and Professor Graetz.

On Thursday, we will pick up the same subject with representatives from business and from labor.

And again, we thank our guests and we thank our long suffering Reporter over there.

[The prepared statement of Senator Hatch appears in the appendix.]

[Whereupon, at 12:52 p.m., the hearing was adjourned.]

HEALTH CARE PREMIUMS AND SUBSIDIES

THURSDAY, MARCH 17, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Pryor, Rockefeller, Daschle, Breaux, Dole, Danforth, Chafee, and Durenberger.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished witnesses and our honored guests. This is a continuation of the hearings that the Committee on Finance has been holding on health care matters for almost a year now. I wish I could say things are clearing up, but we are complexifying very nicely.

This morning's hearing is on health care premiums and subsidies. It is the second of two such hearings. Senator Packwood has to be in the Commerce Committee and will be a little late for this one. I know that Senator Chafee has asked to make an opening statement and others will do as well.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Well, Mr. Chairman, in all fairness, it is just a very brief statement and it does not deal with the actual matter before us. But I just wanted to take this opportunity to express my deep concern over the way our relations with China are being conducted at the present time.

I do not believe that the actions of the administration are going to achieve either of the two goals—one, to improve the condition of human rights in China; or, two, improve the ability for Americans to trade with that nation. I know others may have different views on this, but I believe hectoring the proud nation of China to do what we want them to do is not going to produce the results we seek.

I just wanted to take this opportunity to express my deep concern over the way things are proceeding.

Senator BAUCUS. Mr. Chairman?

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. I would like to address the same subject. Frankly, I think the administration is doing a good job in dealing with this issue. It is because the issue is very complex. I think all Americans would like to see China move much more aggressively in addressing human rights concerns.

I think most Americans would also prefer to work with China, all the various levels—commerce, trade, political level, scientific level, environmental level. China is a great nation. China is growing at a tremendous rate. The United States has very important economic, political, cultural and other interests in China and the administration, I think, is doing a very good job with a very difficult delicate situation.

I know in speaking with many people within the administration that they are working diligently to try to grapple with and deal with the enforcement position we find ourselves in. I think that most Americans would like to find a solution which addresses both human rights problems that we have with China, as well as the economic, as well as pursue an economic solution with China at the same time.

It is not an either or situation. To say it is either or I think is being a bit simplistic and I know the Senator from Rhode Island did not suggest that in any way whatsoever. But I do think that the administration is doing a good job, a very good job, with a very difficult situation, which does not call for an either or result, rather one that is much more sophisticated, much more creative and the administration is working to find that creative sophisticated solution. I think we will find it when it pays out.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. No, Mr. Chairman. I do not want to prolong this because that is not the subject before us. The witnesses have come a long way. I feel we are playing with fire out there, with tremendous potential adverse consequences for our Nation.

The CHAIRMAN. Can I suggest that we will be holding a hearing on China MFN in April, which is next month, and this will be a chance to talk about it. We might ask the Secretary of State to come and talk with us in our back room.

Thank you for raising a very appropriate subject.

Senator CHAFEE. I would appreciate that. I think that would be helpful, Mr. Chairman, to have an opportunity to visit with Secretary Christopher in the back room.

The CHAIRMAN. I am seeing the President later today on these matters and I will issue that invitation on behalf of the committee.

Mr. Baucus?

Senator BAUCUS. I must say, I think the solution is ultimate at least to get over the hump of the next several months and find a solution. Then after that not condition MFN on human rights. Use other tools to address the human rights problems in China. I do think that is where we are going to end up.

Senator CHAFEE. Well, I certainly hope that. I think that every year coming back to this MFN on—first of all, as I have said so many times, MFN, most favored nation, violates the truth in labeling law.

The CHAIRMAN. Now wait. We have changed that. Quick. Help. Marcia. Nondiscriminatory treatment.

Senator CHAFEE. Well, your nondiscriminatory treatment label has not quite caught on, Mr. Chairman.

The CHAIRMAN. Well, I cannot even remember it myself, but Marcia can.

Senator CHAFEE. NDT, somebody will think it is a pesticide.

The CHAIRMAN. Enough. Enough.

Senator Pryor, good morning.

Senator PRYOR. Good morning.

The CHAIRMAN. Now, to our subject matter, and we will indeed get on to this other matter. This is a hearing on health care premiums and subsidies. The first of our witnesses as recognized here, for St. Patrick's Day, are Blakeley, Brennan, O'Flinn, and Sweeney. [Laughter.]

Ann Blakeley, who is Chief executive Officer of the Earth Resources Corporation and is appearing on behalf of the National Federation of Independent Business. Ms. Blakeley, we welcome you.

If everybody will try to stay within about a 5-minute compass, it will give us plenty of chance to have conversation afterwards. Mr. Sweeney is on his way.

Ms. Blakeley?

STATEMENT OF ANN BLAKELEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, EARTH RESOURCES CORPORATION, ORLANDO, FL, ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Ms. BLAKELEY. Thank you. Good morning. My name is Ann Blakeley and I am the President of Earth Resources Corporation of Ocoee, FL. I employ 25 people and my company specializes in the management of particularly or high-hazard waste, such as compressed gases, reactives, and chemical warfare material.

Today I am testifying on behalf of the National Federation Independent Business. NFIB is the nation's largest small business advocacy organization, representing more than 600,000 small business owners in all 50 States.

In the short time I have for my opening remarks, I would like to address three myths that continue to cloud the debate over the employer mandate, small business and health care reform. The first myth is that small business does not want health care reform. This is simply not the case.

The cost of health insurance was first cited as the number one problem for small business owners in a 1986 NFIB Foundation survey. Since that time, the cost of health insurance has remained the number one small business problem, becoming twice as critical as the number two problem, which is Federal taxes on business income.

As a result, reforming the nation's health care system has become NFIB's top priority. In my home State of Florida NFIB supported and I personally worked on far reaching health reform legislation that is now law.

However, small business owners cannot support the employer mandate. It will cause job loss in small businesses and when hit hard the newest, smallest, most marginal firms in the economy. Small business survives on cash, not on profitability. Profitability

is critical to long-term survival; however, a profitable small firm can go out of business if it does not have enough money to make payroll and pay bills.

A health insurance mandate would critically impact the cash flow of small business, particularly start-ups in those firms that have not reached a mature enough level to have cash reserves.

This leads me to the next myth that plagues the health care debate. That is the idea that small firms that already provide health insurance would not be hurt by the employer mandate. Speaking for my own company, the President's mandate to pay for at least 80 percent of premiums for all employees and their dependents would create substantial new costs for my business.

I currently provide health care insurance for my employees. Total health care costs for my company is approximately 6 percent of total payroll and employees pay for a percentage of the cost. Under the proposed mandate and payroll caps our costs for providing health insurance would almost double, increasing approximately $37,000 a year.

This represents approximately two nonprofessional positions in my company. This increase assumes that the cap would not exceed 7.9 percent of payroll. Given the fact that the Congressional Budget Office has reported that the employer subsidies that financed the payroll caps are underfunded by $72 billion in the first 5 years of the program, I and other small business owners do not believe the caps will hold.

An employer mandate, the President's and other variations of it, also comes with an increase in time and resources dedicated to new paperwork requirements. Small businesses currently have to maintain payroll records and do tax returns for FICA, Medicare, Federal unemployment, State unemployment, separate records with different requirements for workman's compensation. And if in our case an employer provides a retirement plan such as a 401K separate records with different requirements to administrate that plan.

These records do not include other personal record keeping requirements, such as those required for COBRA and documentation requirements for hire/fire decisions.

Another area of concern about the employer mandate is the proposal to pass a standard benefits package consistent with a Fortune 500 plan. This is not what most small firms offer and would be too highly priced for many small employers.

When my first was smaller and new, we offered a basic benefits package that we could afford. As my business has matured, we have increased the benefits we offer. Today our health insurance plan provides most of the features proposed in the President's plan with notable exceptions such as children's dental and vision.

The third myth of the health care debate is the claim that the vast majority of small businesses already provide insurance to their employees. This too is false. The Congressional Budget Office reports that only 39 percent of firms with fewer than 25 employees currently provide health insurance.

Firms of this size account for more than 9 out of 10 employers in America. Most of these firms cannot afford health insurance and an employer mandate would have a devastating effect on the vast

majority of main street businesses resulting in more job loss and business failures.

One final word about the employer mandate. Small business owners do not trust mandate compromises that either exempt some employers or lower the level of mandatory payment.

Mr. Chairman, as you said last September while commenting on the financing of Federal entitlements, in the past we have all been wrong about costs. And small business owners know that once you write into the law that health benefits are an employer responsibility, employers will inevitably be tied to required costs over which they have no control and one which would certainly go over time.

I ask you to pass health care reform that brings costs down, increases access to coverage and does not include an employer mandate. Health security should not come at the expense of job security in America's small businesses. Thank you.

[The prepared statement of Ms. Blakeley appears in the appendix.]

The CHAIRMAN. Should we record that the National Federation for Independent Business in the person of Ann Blakeley is the first witness this year to finish her testimony in full and under time. I think that is sort of equivalent to on time and under budget. [Laughter.]

The CHAIRMAN. I really want to congratulate and thank you. You were very succinct. We will get back to you.

Senator PRYOR. That is why, Mr. Chairman, she is in the business of waste management.

The CHAIRMAN. Yes, I suppose she had better get it right the first time. [Laughter.]

Thank you, Ms. Blakeley.

And now, Mr. Brennan, who is the chairman of the board and CEO of Montgomery Ward on behalf of the National Retail Federation. Mr. Brennan, we welcome you.

STATEMENT OF BERNARD F. BRENNAN, CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER, MONTGOMERY WARD AND COMPANY, AND CHAIRMAN, NATIONAL RETAIL FEDERATION, CHICAGO, IL

Mr. BRENNAN. Thank you, Mr. Chairman. As you mentioned, I am Chairman of the Board of Montgomery Ward, and the National Retail Federation. I thank you for the opportunity to testify today on behalf of the National Retail Federation on the health care issues of importance to retailers.

Montgomery Ward is a Chicago-based company. We have 60,000 employees. We offer comprehensive health care to all full-time employees and part-time employees working over 30 hours.

We have a history of health care support dating back to 1912 when we were the first company in America to offer such a plan to our employees.

The CHAIRMAN. Is that right?

Mr. BRENNAN. We support the goal of affordable health care for all Americans. We support the following important reform measures—control of health care costs, voluntary health care purchasing groups, managed care and utilization reviews and elimination of

preexisting conditions, and finally, guaranteed renewable and portability of coverage.

The retail industry itself employs 20 million people, 1 of 5 in the U.S., 25 percent of the recently unemployed find jobs in retail and we have created 3.4 million jobs since 1979. The issue, however, is productivity. Let me share some data with you. Each full-time retail employee produces $1,740 in earnings to their company, compared to $6500 in earnings for a manufacture employee, or it takes 3.7 more retail employees to produce the same earnings as a manufacturing employee.

Remember, I said each full-time retail equivalent contributes $1,740 to their company. Now the cost of the administration's health care plan based on CBO estimates would be $1,656 per year or 95 percent of the earnings contribution for a single coverage employee; and $3,864 or 222 percent of the employee's earnings contribution for family coverage. The point is, we simply cannot afford these costs.

The health care employer mandate imposes a $17.1 billion increase on the total retail industry, which is 59 percent of the total corporate increase of $28.9 billion. The survey of 10 retailers employing 1.3 million employees shows that we would experience a 90 percent increase in health care costs.

The industry cannot absorb or pass on these costs through price increases. So we feel the direction of health care reform is of vital importance. We feel that government programs are often upon enactment merely a starting point. Starting down the wrong road, even with a timid step could quickly turn into a fiscal quagmire.

An employer mandate is simply an entitlement which is funded by business. Now certainly you all know the nation's track record relative to entitlement programs. In 1965 it was estimated that by 1991 Medicare would cost $9 billion per year. The actual cost in 1991 was over $100 billion per year.

The Federal Medicaid Hospital Subsidy Program was estimated by the CBO to be $32 million a year in 1987. In 1992 it was $10.8 billion. Once begun, governmental programs are often irreversible and obviously change as to direction and growth.

So we believe we must be sensitive to jobs and the economy. The retail industry has and plans to continue to increase employment, but massive cost increases would make this impossible. Numerous studies indicate that from $500,000 to 3.1 million jobs would be lost under the employer mandate. And, of course, that is consistent with mainstream economic thought.

Lester Thoreau of MIT stated that Europeans have taught us that mandated benefits end up pricing labor out. To summarize our concerns, we believe health care reform is essential, but reform must focus on covering Americans without health care, controlling costs and reducing bureaucracy.

Labor intensive, low margin industries cannot absorb the massive cost increases that the mandate would require. An employer mandate would tragically cause many of the individuals most in need of health care to lose something they and their families cherish far more and that is their employment.

Since a composition of the 38 million Americans without coverage is as diverse as the reasons for lack of coverage, we suggest that

Congress undertake a series of targeted changes that would reduce the size of this group and permit a workable solution.

So in summary, as a representative of a concerned industry, we want to continue to serve our customer's needs while growing jobs for millions of Americans. We are ready to work with Congress to achieve health care reform, to provide access for all Americans without jeopardizing our economy, while addressing the critical issues that are raised today.

Thank you.

[The prepared statement of Mr. Brennan appears in the appendix.]

The CHAIRMAN. Something has to be done. Twice in a row on time and under budget.

Mr. BRENNAN. She put the pressure on me, Mr. Chairman. I had to move fast. [Laughter.]

The CHAIRMAN. No wonder we are scaring the Japanese into the hole there.

Well, Mr. O'Flinn I am sorry to have to say, sir, that you are next in this competition. Mr. O'Flinn is manager of Corporate Benefits and Regulatory Affairs for the Mobil Corporation. He appears on behalf of the ERISA Industry Committee. That is a somewhat confusing title. You mean businesses which have ERISA coverage and concerns, is that not right?

STATEMENT OF CHRISTOPHER W. O'FLINN, MANAGER, CORPORATE BENEFITS AND REGULATORY AFFAIRS, MOBIL CORPORATION, FAIRFAX, VA, ON BEHALF OF THE ERISA INDUSTRY COMMITTEE

Mr. O'FLINN. Yes. Thank you, Mr. Chairman. Our organization consists of 125 of the largest employers in the United States. These are employers that sponsor comprehensive benefit plans and all told, the medical plans that our members sponsor cover about 10 percent of the population of the country.

The CHAIRMAN. Right. Sir, would you mind bringing your microphone just a bit closer. The persons behind will find it easier to hear you.

Mr. O'FLINN. Thank you, Mr. Chairman.

The CHAIRMAN. Good morning and welcome.

Mr. O'FLINN. And members of the committee, ERIC, as we call the ERISA Industry Committee, has been dealing with health care reform comprehensively for the last 2 years. Hopefully, the members of the committee are familiar with our positions. We feel that we represent the best business thought on the matter of health care reform.

Today in these brief remarks I would like to briefly state our position on employer mandates and financing and then——

The CHAIRMAN. May I just say, please, do not feel under any pressure with regard to time. [Laughter.]

Mr. O'FLINN. That is very gracious of you, Mr. Chairman, thank you.

After stating the position, I would like to talk about the supply/demand situation in health care because we feel it has profound implications on the question of mandates and pricing and how the

country achieves its goal of universal coverage, which is a goal that ERIC endorses.

On the subject of mandates, we believe an individual mandate is the best route to universal coverage. We believe this notwithstanding the fact that virtually all of our members contribute today to health care more than any of the leading mandate proposals would require.

And we say this despite the fact that our members would benefit tremendously from the elimination of cost shifting which an employer mandate would achieve. Why do we say this when it is apparently against our interests? Because we simply believe that we cannot sign on to a specified percentage of an unknown cost.

That is a business judgment that virtually none of our members are prepared to make. We are not prepared to take on that kind of responsibility.

Speaking now on financing, we recognize that there are people who will need subsidies to afford coverage. We feel that these subsidies should be financed by a broad-based tax base and that it should be raised by the Federal Government. It should be budget neutral. It should be clear what the cost is and there should be accountability and at the Federal level.

I would like now to talk about the supply and demand situation.

The CHAIRMAN. May I just say, sir, I want to be clear what you said. You want us to increase taxes but be budget neutral. That is what I heard.

Mr. O'FLINN. Our position is that the health care reform outcome should be budget neutral between the subsidies given and the revenues collected to pay for them. That would be our position, Mr. Chairman.

The CHAIRMAN. I follow that.

Mr. O'FLINN. With respect to the supply and demand situation, we have an unusual situation in the medical sector. The cost of medical care has been rising alarmingly most particularly since 1987. The number of people who are refusing to purchase the coverage or who cannot afford the coverage is increasing; and yet this is a sector that is characterized by excessive supply.

How can it be in a sector that is characterized by excessive supply that prices are rising at an alarming rate? We believe that this has happened because the demand side of the sector is inelastic and, specifically, health care purchasers do not have or did not have the knowledge or the infrastructure to deal with the supply side of the medical sector. Or in plain English, sick people do not negotiate with their doctors regardless of the fee and they do not negotiate with their hospitals regardless of the number of empty beds they see in them.

This situation is changing. It is changing very dramatically right now. At two major oil companies, company costs for medical care is down 20 percent this year. Employee costs are down about 8 percent in similar companies. And the fundamental driver is that professionals, knowledgeable professionals, are negotiating with hospitals and doctors long before any illness occurs on behalf of the patient and they are achieving dramatic results.

Senator CHAFEE. Sir, I am not quite sure I understand that. The costs for the companies you say are down 20 percent.

Mr. O'FLINN. That is correct.

Senator CHAFEE. And the costs for the individual are down 8 percent. What individuals? Do you mean individuals who are employed by your group, your companies in your group?

Mr. O'FLINN. Yes, Senator. I am speaking of the company premium for the coverage, down 20 percent; and I am speaking of the employee premium for the coverage, down 8 percent.

The CHAIRMAN. There is an 80/20 mix or a 60/40 mix?

Mr. O'FLINN. Yes, that is right. And the fundamental reason——

Senator CHAFEE. Overall within your group, members of ERIC, there is a copayment for the insurance?

Mr. O'FLINN. That is correct. There is a copayment for the premium and then typically there is a copayment for the benefit as well.

The CHAIRMAN. Well, we had Alain Enthoven on Tuesday saying that CAlPERS has negotiated a 1.1 percent decline in its premium for the coming year. We have been hearing this testimony that price cost containment is taking hold.

Senator CHAFEE. What I do not understand is the 20 percent decline and the disparity with other categories of insured.

The CHAIRMAN. We will get to that. John Sweeney is going to explain to you about corporate America, you see.

Senator CHAFEE. All right. [Laughter.]

Senator BAUCUS. I think it is important here, too, Mr. Chairman, just to remind us all that is true in some isolated cases. That is not true for all in America, because in the United States health care costs generally, for the country as a whole, are continuing to rise. In fact, the 1994—or 1993, I have forgotten; it is either historical for 1993 or scheduled for 1994—is 12.5 percent increase over the prior year.

If you look at each year for the last decade of the percentage by which health care costs generally in this country have risen for each year in the past decade, it is flat with a slight increase. In the last year it is about 12, 12.5 percent increase.

So even though it is true that for some companies premium costs have declined, even though it is true that CAlPERS reduced its premium by 1 percent, those tend to be segmented, isolated experiences that is not true generally for the country overall. That is something we have to always keep in mind here.

Senator CHAFEE. I think Mr. O'Flinn's point was though that where you have a bargainer for you, a bargainer that is representing the company or the individual or both in dealing with the providers you get some cost reduction.

Mr. O'FLINN. That is exactly right. Both Senators, you are both right.

Senator CHAFEE. You will not lose any points that way. [Laughter.]

Mr. O'FLINN. I am over the time limit, so I have lost that. But I would make this point, Mr. Chairman, which is the essential point. Yes, it is true, we have had tremendous cost increases. There is a tremendous overcapacity.

EBRI puts the hospital over capacity at about 30 percent based on——

The CHAIRMAN. I am sorry?

Mr. O'FLINN. The Employee Benefit Research Institute.

The CHAIRMAN. EBRI.

Mr. O'FLINN. Points out that hospital occupancy rate is about 70 percent in this country based on today's actual admission rates, actual number of days per 1,000 citizens.

But we hear from HMOs that the hospital admission rates per 1,000 can be cut in half and have been cut in half under their experience. Well, if you apply the HMO hospital rate per 1,000 which is about 250 hospital days per 1,000 citizens against today's rate of about 450 per 1,000 citizens with today's rate producing 30 percent excess capacity, the excess capacity in the hospital is astounding. It is over 50 percent.

The same organization, the Employee Benefit Research Institute, has similar figures for physicians. This supply/demand imbalance is completely inconsistent with a rise in prices. Prices must go down providing the market is allowed to operate in a rational way. Our hope would be that you would act to encourage the market to operate in a rational way.

[The prepared statement of Mr. O'Flinn appears in the appendix.]

The CHAIRMAN. Could I just say, Mr. O'Flinn—and we will be getting back to general questions—but we continually are presented data to the effect that there is overcapacity in hospitals, for example. You can interpret that as a sign of advances in medicine as against poor management. I mean, the Hill-Burton Act is not to blame for everything.

I believe I was told just the other day by Dr. Paul Ellwood that 60 percent of surgical procedures involve 1 day or less in the hospital. Well, that is an advance. That is good. And that will have the consequence of a 70 percent occupancy rate which marks, in effect, a decline in costs in the long run.

And you have these adjustments which take place with any changes in technology. In that sense this kind of activity is very close to technology, but we will get back to that.

Mr. Pollack, good morning, sir.

Mr. POLLACK. Good morning. I am happy to see.

The CHAIRMAN. Yes, I was saying to Senator Dole, we have Blakeley, Brennan, O'Flinn and Sweeney, and here is poor Pollack. [Laughter.]

Mr. POLLACK. I truly feel like an outcast and I thank Mr. O'Flinn for taking the pressure off of me.

The CHAIRMAN. We are very happy to have you here on behalf of Families USA..

STATEMENT OF RONALD POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, DC

Mr. POLLACK. Thank you, Mr. Chairman. Mr. Chairman, in the testimony I would like to focus on one key element that I think has not yet received adequate attention: That is the question of the affordability of insurance premiums under the different approaches, particularly the approaches that are employer based versus those that are individual based.

Obviously, if these premiums are unaffordable, then we are not going to achieve the goal of universal coverage. I have heard Con-

gressman Cooper say, for example, that because his plan cosponsored by Senators Breaux and Durenberger provides subsidies up to 200 percent of poverty, that this group of people is taken care of through the subsidy mechanism.

What we wanted to do is examine that and see what was left for individuals and families to pick up, because I would suggest to you that what is left for them to pick up is not affordable.

If I may, Judy Waxman—not to be confused with Vanna White—who many of you know from her work on the Pepper Commission—will help me with the four charts that we have prepared for you.

The CHAIRMAN. Ms. Waxman, we welcome you to the hearing room.

Mr. POLLACK. Mr. Chairman, the chart you have here is an abbreviated version of what you see in Table 3 of our testimony. What it does is, take a look at a family of four, composed of two adults and two children, and it assumes a total premium cost as in the Health Security Act of $5,565. That is CBO's estimate of the premium costs under the Clinton bill.

We took a look at what the premium burden would be for families under the Health Security Act. Then we applied the sliding-scale subsidies under the Cooper-Breaux-Durenberger approach as well as under the Chafee approach.

Let us look at two different sets of numbers. At 150 percent of poverty, under the Health Security Act, the premium burden for a family with an income of $22,200 would be $866 or 3.9 percent of income.

Under the subsidy sliding—scale system in the Cooper-Breaux-Durenberger proposal, it would require a burden of $2,783 or 12.5 percent of income. Under the subsidy mechanism—in the Chafee plan—I do not mean to say it is the Chafee bill—the premium burden would be $1,988 or 9.0 percent of income.

Let me give you two additional sets of figures. At 200 percent of poverty—that is, a family of four earning $29,600—under the Health Security Act, that family would be paying a little over $1,100 or 3.8 percent of income. Under the Cooper-Breaux-Durenberger approach of subsidization, it would be $5,565 or 18.8 percent of income.

And if I may just translate that, what that means is 10 weeks of pre-tax income devoted just for premiums. That does not include that portion of income devoted for deductibles, coinsurance and other uncovered services. But just for premiums it would require 10 full weeks of pre-tax earnings. Under the Chafee type subsidization plan, it would be almost $4,000 or 13.4 percent of income.

If I may, we will take the same situation for a one-person household and we will illustrate what happens for that person. Again, I am going to use the CBO numbers for the premium worth of the Health Security Act, which is $2,100 for one person living alone. At 150 percent of poverty, the Health Security Act would require $420. Under Cooper-Breaux-Durenberger, it would be $1,050 or 9.5 percent of income. That is approximately 5-weeks worth of pre-tax income. Under a Chafee-type subsidy it would be $750.

At 200 percent of poverty, under Cooper-Breaux-Durenberger it would be $2,100 or 14.3 percent of income. That is 7 weeks of pre-

tax income. Under a Chafee type subsidy it would be 10.2 percent of income.

I suggest to you, Mr. Chairman, that under these individual-based approaches the burden that is being borne by the individuals and the families is too large a burden for them reasonably to bear for us to expect that those individuals and those families would be able to afford to purchase just the premium portion of their responsibilities.

I have two other charts which I can do quickly, or if you want me to——

The CHAIRMAN. Please do.

Mr. POLLACK. All right.

The CHAIRMAN. Would you give us the number in your prepared testimony?

Mr. POLLACK. What pages?

The CHAIRMAN. What table are we in in your testimony?

Mr. POLLACK. All right. With respect to the next table we are on page 10.

The CHAIRMAN. Table 5.

Mr. POLLACK. Table 5, and you will see the lower example is the one that is illustrated here.

What we tried to do was to examine what the Federal fiscal implications are of trying to protect families and businesses in a similar way.

In this part of our analysis we chose the goals of the Health Security Act—the Clinton bill. One goal in the Health Security Act is to make sure that no family would be required to pay premiums in excess of 3.9 percent of income. We think that is reasonable.

The same Health Security Act tries to place an upper limitation on what businesses would be paying by placing a limitation at 7.9 percent of payroll that businesses would have to pay.

The CHAIRMAN. The largest?

Mr. POLLACK. That is the largest portion, yes. So we tried to take a look at these different examples and see what the fiscal implications would be to achieve those goals with an individual-based approach versus an employer-based approach.

And you will see the subsidy requirement to the Federal Government is rather significantly different. Under an approach that is based on an employer, financed system, the amount of subsidy required by the government in order to keep the individual's premiums at no higher than 3.9 percent and the employer's burden at no higher than 7.9 percent.

Under an individual-based approach, in order to protect the individuals again as well as the employer, the amount of subsidy required by the Federal Government is more than three times as much, $1,515.

Let me use one other illustration for you. You will find that on Table 6 on page 11 of my testimony. Here we are taking a look at a family of four with $30,000 of income, full-time worker. Again, the goals are the same, 3.9 percent limitation on families; 7.9 percent limitation on businesses.

The amount of government subsidy required under an employer-based approach is $2,082. The Federal subsidy needed in order to achieve those exact same goals is double that, or $4,395.

Now let me conclude as to what concerns me with these numbers. Clearly, under an individual-based approach, in order to achieve the same goals of providing income protection for families and protection for businesses, it is going to cost the government more.

So, therefore, it requires Congress to make a choice—either come up with additional revenues through an individual-based approach or skimp on the protections that are provided to individuals and families as those first two examples demonstrated, such that those families will be unable to afford the premiums, let alone the deductibles and coinsurance and uncovered services.

If I may leave you with just one thought, I know that there are going to be very careful deliberations on both sides of the aisle about the best mechanisms for achieving universal coverage, perhaps incorporating approaches that are individual-based and employer-based. I just urge you, no matter where your starting point is on this, to please take as a given that you are going to have to come up with a subsidization mechanism that is going to make sure that individuals and families do not bear the kinds of burdens that were demonstrated here.

It is simply unrealistic to assume that a family that is required to spend 10 weeks of pre-tax wages as a premium is going to find it affordable to get health insurance. And so whatever mechanism you use, place a serious limitation on what the individuals and families are going to have to bear and make it reasonable, as I believe the Health Security Act does, and then work from there.

Because if you do not do that, we are not going to get universal coverage.

The CHAIRMAN. Thank you, Mr. Pollack.

[The prepared statement of Mr. Pollack appears in the appendix.]

The CHAIRMAN. And now to conclude our presentations, we have the great pleasure of welcoming to the Finance Committee John Sweeney, who is International President of the Service Employees International Union, AFL–CIO. The membership, I believe, is just past one million persons. He appears before us as chairman of a committee on health care established by the Executive Council of AFL–CIO. Good morning, sir.

STATEMENT OF JOHN SWEENEY, PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL–CIO, WASHINGTON, DC

Mr. SWEENEY. Good morning, Mr. Chairman. I am delighted to be here. I would at the outset like to congratulate you as Chairman on the award that you received, the Humanitarian Award, that you received last night from the American Ireland Fund and to also wish all the members of the Committee a Happy St. Patrick's Day.

The CHAIRMAN. Now that is a good way to get started.

Mr. SWEENEY. I am happy for the opportunity to present the AFL–CIO's views on employer responsibilities with regard to health care coverage. In the state of the union address, President Clinton said that he would veto any health care reform legislation that did not guarantee universal coverage.

The 16 million working men and women who are members of the AFL–CIO, affiliated with unions, could not agree more. When 39

million Americans have no health insurance, it is time to put an end to partisan bickering and provide all Americans with the security of health insurance that can never be taken away.

If we can agree that health care coverage is a social good of such overwhelming importance that it warrants our assuring that everyone has it, then the question becomes how to provide it.

The AFL–CIO believes that short of a tax financed social insurance system, an employer mandate is the only feasible way to security health coverage for all Americans.

I want to make four arguments in support of this position. First of all, requiring all employers to contribute to the cost of their employee's health insurance, builds on our existing system. Among the 39 million Americans who lack insurance, 85 percent belong to families that include an employed adult. A system that requires all employers to contribute will reach the vast majority of the uninsured.

My second point is that the system that we have right now, which I would characterize as a voluntary employer-based system is under tremendous stress because of rapidly rising health care costs. With every passing day, the incentives grow for companies to scale back their coverage or eliminated entirely in response to competitive pressure.

The growing disparity in labor costs between firms that provide health insurance and those that do not is generating serious distortions in the labor market. The dramatic increase in the number of part-time and contingent workers is being driven by the desire of employers to avoid the cost of health benefits.

This is why health care has become the number one issue at the bargaining table and the number one cause of strikes. When we go to the bargaining table the primary reason cited by our employers for wanting to eliminate or scale back our health benefits is that their competitors are not providing insurance. This is especially true in low-wage labor markets.

My third point is that the present system of voluntary coverage is unfair because it allows employers who do not provide insurance to shift costs to those who do. Many employers pay more than their fair share because they are covering the working spouses of their employees as well as paying extra to cover the uninsured. In essence, they are subsidizing their competition.

Requiring all employers to contribute to the cost of their employees' health insurance will level the competitive playing field. It will also reduce costs for the majority of employers who are already providing health insurance. This is also one of the principal arguments against using an individual mandate rather than an employer mandate to obtain universal coverage.

In addition to the fact that such a mandate would unfairly burden low and moderate income families and be extremely difficult to administer, it would also do nothing to address the problem of cost shifting. That is why a number of leaders of large and small businesses are supporting the idea of shared employer responsibility.

Our own union, as well as many others, are members of the National Leadership Coalition for Health Care Reform, which includes among its members 65 of this Nation's major businesses which endorses an employer mandate.

And if I may, I would like to insert into the record a list of the members of the National Leadership Coalition.

The CHAIRMAN. Please do. So ordered.

Mr. SWEENEY. Finally, I want to rebut the argument that requiring all employers to contribute will cost jobs. The fact is that the present system is already costing people their jobs and the situation is getting worse. Employers who are currently providing insurance are losing market share to competitors who are not.

One of our own local unions in Florida, Local 750, which represents building service workers in Orlando, reports that one of its employers lost a contract with Delta Airlines that it had held for 8 years to another contractor who did not provide health insurance and was able to underbid the union contractor.

Those workers lost their jobs and their health insurance in one fell swoop. The bottom line is that the system of employer-provided health insurance is collapsing. Unless all employers are required to contribute, firms will continue to limit their coverage or drop it entirely.

Thank you. I would be happy to answer any questions.

[The prepared statement of Mr. Sweeney appears in the appendix.]

The CHAIRMAN. Thank you, sir.

We thank our panel. Here we are in good time and good spirits.

Senator Dole, you have been faithful in attendance to these matters. We will defer to you as Republican Leader if you would like to ask questions.

Senator DOLE. I will wait a while.

The CHAIRMAN. As usual, he would like to wait a while.

Mr. Chafee, you are first, sir.

Senator CHAFEE. Thank you very much, Mr. Chairman.

First, I would like Mr. Brennan to repeat a statistic that he gave us at a breakfast we were at, which was astonishing to me. Perhaps you could repeat that here, Mr. Brennan. I think you have 61,000 full-time equivalent employees in your company, and you put out every year 260,000 W–2 forms.

Mr. BRENNAN. Well, on the average for every job we have, from 3½ to four employees because of the turnover in retail, the part-time turnover. So it is well in excess of 200,000, close to 240,000 against an employee base of 60,000. That is correct.

Senator CHAFEE. So it is nearly one to four.

Mr. BRENNAN. That is correct.

Senator CHAFEE. Which as a statistic, astonished me.

Mr. BRENNAN. May I pick up on that, Senator?

Senator CHAFEE. Sure.

Mr. BRENNAN. The issue on part-time as it relates to retail is not a function of lowering costs, it is a function of when customers shop for merchandise. Our stores are open 7 days a week, 12 hours a day and it is a function really of addressing customers rather than any issue pertaining to health care costs.

Senator CHAFEE. Mr. Sweeney, I know that it is said in the unions that the unions have negotiated health benefits in lieu of wages. Is that true?

Mr. SWEENEY. That is very true.

Senator CHAFEE. Then I would ask Mr. Pollack if in his assumptions that you put up in your various charts there, do you take that into account? Do you take into account what you might call the lost wages for the families where the employer pays the coverage?

In other words Mr. Sweeney, the unions have frequently said that they are receiving lower wages because the employer is paying it. In your charts you show that since the employer is paying for coverage; and your charts always come out very, very favorable to the employer-based mandate which you support; have you taken into account the lost wages to the employees as a result of the employer mandate.

Mr. POLLACK. Mr. Chafee, when we talk about targeting those people who do not have coverage, as I have tried to do in my testimony, these people have not lost wages because they do not have health care coverage. I do not know how to respond to your——

Senator CHAFEE. In other words, you make a series of predictions there in your charts. If the income is $24,000 for a four member family and the employer mandate such and such occurs; do you take into your assumptions that there are lost wages in the income total as Mr. Sweeney points out?

Mr. POLLACK. There probably would be some reduction in the rate of increase. What you are talking about is likely. That would happen over a period of time—most economists say over a long period of time. So I do not know how to respond to that question, sir.

Senator CHAFEE. Well, I think we have to take that into account. I do not think you can—and I am not suggesting you are just breezing past it, but it is a significant factor as Mr. Sweeney and those who gave testimony before; that by taking health care insurance, employees have undergone either a reduction in wages or a reduction in increase in wages.

Mr. POLLACK. Senator, if you are asking me to concede that employer-based coverage is going to have some adverse effect on wages, I would agree with that over the long term. You are absolutely right about that. We do not disagree about that.

The point I am trying to make, Senator, is that as you take a look at whatever subsidization system you have, that subsidization system must realistically be calculated so that families can afford to pay for those premiums. I suggest taking a look at those examples and we can go through any other examples you want. It is just an unrealistic burden under your bill and the Breaux-Durenberger bill.

Senator CHAFEE. I am going to obviously review your testimony because I want to look at the charts. What are your assumptions? For example, do you assume any continued employer payment of employee premiums? In other words; as has been pointed out by our first witness, Ms. Blakeley and others; the employer makes some payments. Now not 100 percent. What assumptions did you base your charts on?

Mr. POLLACK. I am not assuming, by the way, in these charts that there is any dropping in coverage on the part of employers under an individual-based system. I suggest to you that there probably will be. But I have not made any assumptions about that.

In fact, if that was factored in, the cost under an individual-based system would be even more costly.

Senator CHAFEE. Okay.

Mr. POLLACK. But I made no assumptions about that.

Senator CHAFEE. Do you have the same benefits and the same premiums for each of the plans?

Mr. POLLACK. Yes, we do. And under the other charts that we have, we have different premiums. Based on your bill, for example, Senator, we did this both ways so that you could see it both ways. They produce essentially the same results.

In Tables 1 and 3, and this reflects what you see on Table 3, we are assuming the Clinton plan premium for a family of four of $5,565—CBO has given it to us—and for an individual of $2,100. We assume that for all plans.

Now in Charts 2 and 4 we play that differently based on the structure of your bill, Senator, and on Senators Breaux and Durenberger's bill. You will see, for example, on Table 2, footnotes b and c on page 5, the different assumption that reflects more of the architecture of your bill and Congressman Cooper's and Senators Breaux and Durenberger's architecture. We used different assumptions based on those bills.

So you have it both ways. And essentially, they produce similar results.

The CHAIRMAN. Good.

Senator CHAFEE. Thank you, Mr. Chairman.

The CHAIRMAN. We have your tables and we will be going over them.

Mr. SWEENEY. Mr. Chairman?

The CHAIRMAN. Mr. Sweeney?

Mr. SWEENEY. Mr. Chairman, if I may in response to the Senator's question. We have a study that was done by Lewin Associates, out of control, into decline, the devastating 12-year impact of health care costs on worker wages as well as corporate profits and government budgets.

The CHAIRMAN. We could put it in the record and we would be happy to do. Yes, we appreciate that very much.

[The report appears in the appendix.]

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

The CHAIRMAN. Would other panelists feel free to comment on anything they heard, agreeing or disagreeing.

Senator BAUCUS. I would like to address my questions and comments to Ms. Blakeley and also to Mr. Brennan, by saying, first of all, I am very sympathetic with costs that businessmen, and in some particular case small businesspersons, would have to incur. I say that because I come from a small business State. My State is Montana. We are very much a small business State.

In addition, I might say that I was a member of the Pepper Commission chaired by Senator Rockefeller and I voted against the final Pepper Commission recommendations because it would recommend an employer mandate. I felt that was unfair, it was improper, it would place too much of a disproportionate burden on business.

That was then. We are now faced with a more comprehensive proposal, that is the President's proposal as well as other legislation before us. We are forced to grapple with this question again,

that is the degree to which there should be a mandate at all and if there is employer or individual mandate.

Now the question I am trying to focus on is costs. How are we going to get a hold of cost increases under whatever health proposal we enact? The Congressional Budget Office has examined the President's proposal, and is also in the process of examining others, and has concluded that the President's proposal will save business $30 billion compared with the current structure by the year 2000 and save business health care expenditures $90 billion by the year 2004.

They conclude, again, compared to the status quo, the President's plan will save business that amount of health care spending.

Now some groups are opposed to the Clinton plan. They do not like, and both of you said you do not like, an employer mandate and we get into sometime later the subsidies in the mandate and how that would then affect business.

But the question I am trying to really focus on, how are we going to otherwise control costs. The usual ways that groups who are opposed to mandates say we will control costs, is with insurance reforms, for example, community rating and getting rid of pre-existing conditions and adverse selection and so forth.

But I might say that that only levels the playing field so that people are all in the same boat. It does nothing to address the overall increases in health care costs as the level playing field gets higher. So insurance reform in no way addresses American national health care costs increases. It does not address that question. It does with respect to different business people; it does not as a country overall.

Second, people talk about medical malpractice reform. I am very sympathetic with that. But again, CBO says that medical malpractice reform will address less than 1 percent of health care costs in this country. It is important, but it really does not get to the heart of the problem.

Others tout the 100 percent deductibility of premiums. That is great for the first year, but that is just a one-shot, 1-year reduction in costs to business people. It has no effect in subsequent years because we keep the same in each of the subsequent years. Others suggest that, well, a standards benefit package will help, too.

But I am really trying to get at, if you do not like the mandates and the caps, 7.9 percent of payroll, and with the caps down to 3.5 percent for businesses with fewer than 75 people and wages and so forth, if we are honest with ourselves, how then are we going to control health care costs in this country?

I think there is a lot of wishful thinking about managed competition, insurance reform, you know, medical malpractice reform and so forth. But when we think it through, I do not think that that really is going to get a handle on the increases in health care costs in this country. So I would just like to ask you, what is your suggestion? How are we going to start to control costs?

Mr. BRENNAN. That was a comprehensive question, Senator.

The CHAIRMAN. Thank you, Senator, your time is up once again. [Laughter.]

Mr. BRENNAN. I see I am on yellow already.

Number one, I would say that when you look at the CBO estimates I think any estimates are suspect based upon the empirical evidence. I discussed earlier the original estimates on Medicare, the estimates on the Medicaid subsidy, which are going to be $32 million a year, which were $10.8 billion last year.

Senator BAUCUS. That was an interesting point. But just on that, the fact is Medicare is going up because health care costs are going up generally.

And second, we must remember, since 1974 the premium, the payroll tax that people pay, has gone up insignificantly. It was .67 percent of payroll in 1974; today it is one point something percent of payroll. So it is true that Medicare that has gone up. It is true it has gone up because health care costs in this country have risen so much, not because the program is out of control.

Mr. BRENNAN. No, my point though was, if Medicaid costs have gone up, if health care costs have gone up, in the number of 10 percent per year, the Medicaid subsidy went from an estimate of $32 million to $10.8 billion, the relativity is quite different.

I will get off that issue, but I really question——

Senator BAUCUS. But how do we control costs? That is the question.

Mr. BRENNAN. Okay. I think that is the issue. Let me talk about our estimate of the 38 million that are not insured. I am going to use relative numbers just to make a point.

If you look at 38 million and take 24 percent of those individuals, they are in a situation where they do not have portability. They are in between jobs. If you take those who are affected by pre-existing conditions, that is another 2 million. If you take the 5 million self-employed who do not have deductibility as a corporation has, that is another 5 million.

As you begin to build this up, there are segments that can be reviewed individually before we deal with the overall plan itself. So you made the point that the sense of medical malpractice is not significant. But if we take each of these pieces and begin to deal with billions of dollars and millions of people, before you know it, you are up to an area of 70 to 75 percent of the issues that could be dealt with before you change the entire medical health care plan across the country.

I mean, the issue really is, why do we not look at the things that we are doing today. You have numbers maybe that are better than mine. But I believe that there is a moderation in health care costs taking place right now.

I sit on hospital boards. I am the chairman of the NRF, the National Retail Federation. And if you look at the retail industry in total today, and this is all quite recent, in the last several years, 82 percent of us offer HMOs; 50 percent offer PPOs; 17 percent offer some kind of mental health care, or 75 percent mental health care. We are working aggressively to lower those costs.

I believe the point made by Mr. O'Flinn that action is being taken on the other side by hospitals and medical providers who have to be competitive. So if I could just finish my point, what I would like to say to you is that these are significant issues and why don't we deal with those issues first before we attempt to put

in any mandate or entitlement that could never be changed. That is really my position.

Now, the last point I would make is jobs. The issue here is that the retail industry has one million workers. And if there is the kind of impact we are discussing, an 89 percent increase in costs, will end up in us reducing the employment payroll because, in fact, we cannot afford it.

But back to your issue, I think it is taking each segment by itself, understanding the true costs and understanding what can be done on the other side to offset those costs and deal with this in a logical, pragmatic manner and not try to take an entitlement and overwhelm it entirely.

Senator BAUCUS. I must say, you know, in Montana health care spending by business went up 280 percent in the last year.

Mr. BRENNAN. I would submit to you, sir, as you said, you have a lot of small businesses. If they can be aggregated into purchasing groups, they can reduce those costs from 50 to 75 percent. You need the help and you do need those kinds of organizations. So I understand that.

Senator BAUCUS. My time is more than expired.

Mr. BRENNAN. I am sorry for taking so long.

The CHAIRMAN. Mr. O'Flinn, you wanted to say something.

Mr. O'FLINN. Yes, thank you, Mr. Chairman.

I would like also to respond to the Senator's question. Earlier we talked about over supply of hospitals and doctors and it was pointed out that we have had oversupply for quite a while and it has not seemed to have done anything to lower the cost.

The point I would like to make on behalf of ERIC is that a breakthrough has occurred in the last 15 months or so. New products are being offered, and new infrastructure is being created, to rationalize the buyer and the seller in this medical service sector.

I will give you one example. We had in my company an experiment in September of 1992 in which we approached a local HMO which we offered to our employees and said, all right, you have the participants you want, now we would also like you to sell us your discounts, which you have negotiated with suppliers in this area. We do not want your HMO, we just want your contracts.

That is a new product, never been done before to our knowledge. They sold us those discounts for $4 a month and the cutback in costs after 3 months was approximately $23 a month per head per individual in the area.

At one hospital in this District, a very highly regarded hospital, for some procedures costing $10,000 those contracts resulted in a 70 percent reduction in our costs. And when we got the results of that, and my business is reducing health care costs, we stopped the pilot program and we negotiated those contracts across the country. That is what led to a 20 percent reduction in our costs this year with no reduction in benefit.

What is lacking is utilization of this infrastructure and we would love to see the committee concentrate on insisting that this infrastructure be expanded and used, recognizing that there are forces in play that would stop the rationalization of this market and the lowering of costs that are happening right now, particularly in the States with so-called any willing provider laws.

This is the point that we would make in reply to your question, Senator.

The CHAIRMAN. We have heard that particularly in the past, projections of costs have been underestimated. What we thought would be $3 billion turns out to be $30 billion and so forth.

We have heard a lot of testimony, however, in the last 6 months, along the lines which I believe Senator Durenberger endorses, that we might be on the verge of a very significant reduction in costs as a proportion of GDP.

In any event, it is your time to ask questions, sir.

Senator DURENBERGER. Thank you, Mr. Chairman.

The answer to the question, the excellent question that John Chafee raised, there is only one way to reduce the cost of the subsidies on that and to increase wages—that is to reduce the cost to health plans. We can all agree on that.

The way to reduce the cost of health plans, in response to a question Max raised, I just passed around a copy of Dave Lawrence's article in the Wall Street Journal yesterday. Kaiser has more members in California than are people in Minnesota. So this is not an isolated example of how to reduce health care costs.

You can find this, as some of the witnesses have indicated already, you can find this happening in markets all over America. Max's question was, well,then how do we get the cost of care down explicitly and my answer is to pass Chafee, Dole, Breaux, Durenberger, Jackson Hole II and those parts of the Clinton bill on which many of the rest of you are authors, with the exception of price regulation and the employer mandate. I think that will give it to you.

What it does, and one of the important issues here that I would like to raise with Mr. O'Flinn and maybe others, what it does is substitute for a set of irrational rules in the marketplace some uniform national rules. I think, Mr. O'Flinn, this is one of the points you are making in your testimony.

One of the things that unites many of the people here is the ERISA issue. I think most of us have opposed State by State waiver of ERISA. I know Mr. Sweeney has and many of the AFL–CIO people have as businesses. The net result is, if I understand—you can correct me, Mr. O'Flinn if I am wrong—we need rules for how we buy, which is the issue of alliances and coops; is that correct? We need national rules not State by State rules.

Mr. O'FLINN. That is absolutely correct, Senator.

Senator DURENBERGER. And that we need national rules as to what it is that we buy—insurance rules, insurance pricing rules.

Mr. O'FLINN. There are gaps in the regulation of health care and they should be corrected. We would like to see them corrected at the national level. This is an industry in interstate commerce. The supply side is organized across State lines.

Senator DURENBERGER. And then we ought to agree on what the rules are for accountable health plans as the President has proposed to us so we have national rules; is that correct?

Mr. O'FLINN. That is correct,sir.

Senator DURENBERGER. And we ought to agree on how to design a basic benefit, some instrument at the national level so there is a basic way for everyone to compare these products that they buy. Do you agree with that?

Mr. O'FLINN. We would like to see product rationalization. We would like to see rules that make it easier for people to buy health insurance anywhere in the United States.

The CHAIRMAN. Mr. O'Flinn, we try to keep a lexicon going here. Product rationalization. That does not come across.

Mr. O'FLINN. I am sorry.

The CHAIRMAN. I know you know what you mean, but I am not sure I do.

Senator DURENBERGER. Thank you, Mr. Chairman.

Mr. O'FLINN. I apologize, Mr. Chairman, and to the members of the committee for using trade lingo. In plain English, we think that people ought to be able to buy health insurance without worrying about reading the fine print of the policy in Ohio or Delaware or Maryland.

They ought to know, have some confidence, about what the level of coverage is that they are buying wherever they buy it. That, to us, as Senator Durenberger is implying, means Federal regulation from coast to coast.

Senator DURENBERGER. Mr. O'Flinn, also on the flip side of that, would that imply that we need to eliminate the authority currently being exercised by the States to prescribe specific benefits in health plans, to prescribe State-by-State in different States what providers are going to be covered to restrict entry of certain providers into a marketplace, such as prohibitions against for profit provides, anti-trust rules, medical liability rules.

Would it be your argument then that, let us say, taxes on health plans, taxes on health products, would it be your argument that we ought to eliminate State-by-State rules on this product that we buy and substitute for that a uniform set of national rules by which all the markets can play?

Mr. O'FLINN. That is ERIC's position, Senator. We think you have outlined the reasons for it very well. In order for people to react properly in a market that we would like to see properly balanced between suppliers and purchasers, they have to know what they are buying and they have to be fully informed. Things have to be a lot simpler than they are now in order to do that.

Senator DURENBERGER. Now if we do all this, I want to ask Ms. Blakeley and Mr. Brennan a question. We still have not dealt with the issue of universal coverage. If in the first step of universal coverage we do what all of these bills imply and that is, we address the problem of low income access, if in fact we were to provide a direct public subsidy as President Bush had recommended, President Clinton is recommending, direct public subsidy for health plan premiums so that up to 100 percent of poverty are premiums fully paid on a basic benefit plan and from 100 percent to 240 percent of poverty the amount declines.

If everyone who came to work in a retail establishment, Mr. Brennan, came with an entitlement to a Federal subsidy for that premium up to 240 percent of poverty or whatever it is, do you not think even under the current voluntary system in which retail industry is paying 77 percent of the premiums already, manufacturing paying 93 percent, do you not think almost every employer in America would be able to pick up the difference or some part of the difference?

Mr. BRENNAN. Well, I think the issue here that you are getting at, at least my issue, is voluntary and competitive. The answer is that some sort of subsidy is necessary. The issue is that if it is a mandate program and it is fixed at a high level, in fact, it has a base and it can only go up, it does not work.

So the answer is yes, recognizing that we maintain a competitive environment. Because what is happening today in health care, as you well know from the State of Minnesota, is that competition worked. Businesses work together on a voluntary basis and work with the health care providers and that is why you made that system work in Minnesota.

I think that is a model. But it is only a model if you are not working under a mandate.

Senator DURENBERGER. I wonder if Ms. Blakeley might respond to that?

The CHAIRMAN. Of course. Ms. Blakeley and then I think Mr. Pollack asked if he could comment.

Ms. BLAKELEY. There is another issue here on the mandate. Yes, I agree a lot of businesses would do that. But you cannot, if you mandate a business you have some businesses that are more mature and can assume some of those things. But what you are doing is setting an arbitrary limit that says because you are not a mature business and you do not have cash reserves, we are going to put X percent of you out of business.

Those people are not working now. What you have done is, you have compounded the problem. One of the things about these charts that I do not think they take into account is it does not have job loss on here. All you are seeing is health care premium.

One of the things on an employer mandate, and every study that I have seen says there will be job loss. So that is an issue that you have to deal with. I agree with what you say 100 percent. You cannot mandate it. Allow business to do business.

The CHAIRMAN. Mr. Pollack, briefly.

Mr. POLLACK. Yes. Senator Durenberger said earlier that he dismissed the cost impact of the charts by saying—if we lower the benefit package, the burden is lowered. Of course, that is true.

However, you should not take much comfort from that because we have tried to do that. Let me give you an illustration of that using the architecture of the bill that you have cosponsored. You will find this in Chart 4.

Senator DURENBERGER. Tell us which bill, because I am on——

Mr. POLLACK. Pardon me?

Senator DURENBERGER. Tell us which bill because I am on two of them.

Mr. POLLACK. That is true. I am now referring to the Cooper-Breaux-Durenberger bill.

If you do not mind, Senator, if I could just ask you to refer to Table 4 on page 7, you will see that what we tried to do here is to take a look at a different benefit package or a different premium that you subsidize.

For your bill we looked at one that is 15 percent lower, because under the bill that you and Senator Breaux have cosponsored, you would subsidize the lowest-priced plan as opposed to the average plan as the Health Security Act does.

So here, instead of trying to come up with a plan of $5,565, we looked at a premium cost of $4,730. And even with that 15 percent reduction, at 200 percent of poverty the burden for family would be 16 percent of income or approximately 2 months of pre-tax wages.

So while you are absolutely right, Senator, in saying that we could reduce the burden for everybody by lowering the benefit package, still when you do that the burden would be much too high.

I want to add one last point. When you reduce the benefit package, what you are reducing in costs in the front end through premiums you are adding in the back end in deductibles and copayments and uncovered services. That is not really doing a favor to most families.

The CHAIRMAN. Thank you, Mr. Pollack.

I guess I want to point out though that at an annual income of $30,000, persons are very much in the median range of family incomes. And if they spend about what we now spend on health care, as a percentage, 16 percent of GDP, is close to the average national expenditure on health.

Mr. Sweeney?

Mr. SWEENEY. Just a quick point, Mr. Chairman.

Senator Durenberger mentioned the Kaiser situation. While it is true that Kaiser has cut the premiums for CalPERS, it is also true that Kaiser has raised the premiums for the City of San Francisco. We have heard some examples today of cost reductions. These are mostly cost shifting rather than cost reductions. We are seeing a number of situations where employers might be reducing their costs, but workers are being forced to pick up more of the costs in terms of additional premium payments and cost sharing.

The CHAIRMAN. A fair point I think.

Senator Pryor?

Senator PRYOR. Yes, sir. Thank you, Mr. Chairman. Mr. Chairman, I am going to make this morning—I will ask a question or two if I might, but I am going to first make a plea. I am going to make a plea to this panel and all of the people who come before the committee who are involved in trying to work out some kind of health care reform package that we can all support and live with and be proud of, I am going to make a plea for something I call rhetorical temperance.

For example, I think that Mr. Brennan, when he cites in his press release that Congress in 1965 said Medicare would cost $9 billion by 1991, and the actual cost is really $100 billion. I think Mr. Brennan—I am not chastising you—but I think all of us ought to back away from some of these types of statements like this unless we tell the full story.

It is very important that we put things in context and in perspective. I think truly that some of these are out of perspective. I think we can temper our rhetoric some. We can cite, for example, your company, Montgomery Ward. If we had a 1965 Montgomery Ward catalog here with us today, we could look at the price of a wheelbarrow, in 1965 as compared with today, or the price of a pair of shoes, a suit of clothes or what have you. We would see perhaps the same escalation costs that we have seen in some of these programs.

We do our very best here to project what we think programs will cost. But all of the additions, the escalation of utilization of physicians, of hospitals, of prescription drugs, et cetera, it is not just our fault that we missed.

Mr. BRENNAN. I understand that. But I would also say to you that we all do project. We run businesses, we run government, and the predictability in government entitlement programs relative to the results is quite substantially different. I understand what you are saying.

Senator PRYOR. I grew up in a small town in Southern Arkansas, almost in Louisiana, just a few miles north, and my father was a local Chevrolet dealer. I remember so well in the late 1940's, my dad got all four children together and he said, you children are going to live long enough to see a Chevrolet automobile cost $2,000. He said you are going to live that long to see that.

Well, that was a projection of sorts. [Laughter.]

Mr. BRENNAN. And he was right. [Laughter.]

Senator PRYOR. Things do not stay the same and I think all of us ought to realize this. The factors that come into play in increasing a program or decreasing a program should be all laid out.

Mr. BRENNAN. I think really you have hit my point right on the head, because what I am really saying is, before we put in a new entitlement program, let us understand the elements of cost and revenue and let us deal with those. So I think we are in agreement.

Senator PRYOR. All right.

Mr. BRENNAN. Thank you.

Senator PRYOR. Now, my question is to Ms. Blakeley. I would like to say, Ms. Blakeley, I think there ought to be a special place in heaven reserved for those who operate a small business today. I applaud you and your 25 employees.

You stated a moment ago in your testimony that if the Clinton plan actually becomes law, your costs are going to increase by $37,000.

Ms. BLAKELEY. Yes, that is correct.

Senator PRYOR. Now, what happens if we do nothing? What will your costs be?

Ms. BLAKELEY. If nothing else is done, our average increase over the last 5 years has been between 2.5 and 3.0 percent per year.

Senator PRYOR. Now, with that increase, are you lowering benefits or is the insurance company lowering benefits for the employee?

Ms. BLAKELEY. No, Senator. We have always increased our benefits as soon as we could.

Senator PRYOR. Those particular policies, can they be cancelled against your employees?

Ms. BLAKELEY. No. Under our group plan any employee in my company is accepted. Is that what you mean?

Senator PRYOR. What about a pre-existing illness?

Ms. BLAKELEY. Pre-existing conditions, I do not have a pre-existing condition clause on my policy.

Senator PRYOR. I see.

Ms. BLAKELEY. You have a probationary period.

Senator PRYOR. I see. I saw a gentleman the other day. He operates a barber shop and has two barbers in his shop. Every month

his premium is $402 a month. He had a prostate procedure back in December. He came out of it in very good shape.

Last week they cancelled his insurance. He has nothing. He is 56 years of age and he has nothing. These are the kind of things that I think we are trying to address here. We are not talking about someone who does not want to pay their insurance.

Ms. BLAKELEY. That is correct.

Senator PRYOR. We certainly are not talking about small business people who prefer not to insure their employees.

Ms. BLAKELEY. My situation is a little different from mostly truly small companies. I have been very, very fortunate and my company is a little more mature than a lot of small companies. There are a number of issues on insurance reform for small business. We have enacted a lot of them in Florida on small business reform that I have not heard anybody in a number of plans that disagree with those things that you are talking about—portability of coverage and pre-existing conditions.

Senator PRYOR. Thank you, Mr. Chairman.

The CHAIRMAN. Right. I think if there is anything the panel will want to know that this committee agrees on is that we are going to take the name of that insurance company in Arkansas. Enough of that. Just enough of that.

Senator PRYOR. This is not an Arkansas insurance company. [Laughter.]

The CHAIRMAN. I am sorry. I am sorry. We will take the name of that company. But no more of that.

Senator Dole?

Senator DOLE. I think the question has been covered by Senator Durenberger, but Senator Packwood, who could not be here asked me to ask a question.

The CHAIRMAN. Please. We explained that he has to be in the Commerce Committee.

Senator DOLE. Right. I think it was covered well enough by Mr. O'Flinn. But I think Packwood's question was, how critical is the maintenance of ERISA to the survival of your self-insured plans. I think it is pretty obvious. You say it is.

Mr. O'FLINN. Yes. I do not want to repeat the conversation and take up time that we might be discussing other subjects. But we happen to think it is critical to the concerns that have been expressed since we had the conversation about controlling the costs.

When you have a State that finds itself in the position of having to expand coverage and finds itself in the position of having to protect the right of pharmacies to continue their 30 percent a year increase in drug costs that we have seen over recent years, and to stymie a program to lower the costs of drugs by offering to selected pharmacies great volume in exchange for lower costs, and then you have a State law come along and say you have to offer the same deal to all pharmacies, which kills the economics of the entire transaction and makes lowering costs impossible, it is time to recognize that this State or Federal issue goes right to the heart of health care reform in our view.

Senator DOLE. Right. But the Governors have a different view on ERISA. But that is why I think we need to make the point.

The CHAIRMAN. We have to deal with this.

Senator DOLE. Right.

Mr. BRENNAN. Senator, the issue is not just real costs as discussed. The administrative costs would be a nightmare. We operate in 42 States. We transfer employees across the States and administratively it would be unbearable.

Senator DOLE. Ms. Blakeley?

Ms. BLAKELEY. Another comment on ERISA, just a separate viewpoint, State viewpoint. What happens particularly in the State Governments is the States are paying for a Medicaid portion—I know we do in Florida—with a tax on policies which are primarily small business policies.

Those policies also have all the mandates of lots of different coverages. What happens is, ERISA plans are exempted from those taxes. Not only do we have additional costs in small business plans on a State level, but we have those additional taxes that the big companies are exempted from. So it is even more regressive for small companies.

Senator DOLE. I noted today in the Wall Street Journal that the Small Business Council says that in their view there is no sense in beating a dead horse, and this is of one small business group that has been supporting the President's plan. They also reject the Chafee plan, sometimes referred to as the Chafee-Dole plan. But in this article——[Laughter.]

Senator CHAFEE. I always know how the plan is doing the way Senator Dole describes it. [Laughter.]

If it is riding high, it is the Dole-Chafee plan. [Laughter.]

Senator DOLE. And they also reject the Durenberger-Breaux plan. [Laughter.]

Which leaves me to believe that there will still be another plan. I think that is what they have decided, not to get too technical.

But getting back to small business, as I look at the information I receive which certainly covers every State, I think, on that side the aisle with the exception of the Chairman and most of the States on this side the aisle.

I think it has been projected that 3,717,500 employers would have higher payroll expenses under the proposed employer mandate. That is 74 percent. You only have 5 million. You know, that is a real problem.

We can talk about employer mandates and have charts that may or may not be accurate, but I think we have to deal with that. I am not certain there are votes for employer mandates or individual mandates. If all the mandates go out the window, we have to find some way to have this goal of universal coverage. This Ms. Blakeley and Mr. Brennan sort of made that point.

Mr. Brennan, if they reduce from 80/20 to 50/50, would that make a difference?

Mr. BRENNAN. Well, any reduction in the percentage would make a difference. There is no question about that. The question is, what really is affordable, both for small business and low-income employers.

Senator DOLE. But you are opposed to it in any event?

Mr. BRENNAN. Well, my point is that we ought to deal with the issues individually rather than an overall mandate. But really I represent both small and large business in the NRF, National Re-

tail Federation, and there is a similar impact on low-income large companies as well as small companies.

Senator DOLE. Do you have charts on how many with three or fewer employees in each State? Do you have it broken down?

Ms. BLAKELEY. In my written statement there is a chart that breaks down just percent of firms offering health insurance by size. But it only goes down as low as—well, fewer than five.

Senator DOLE. I think I am correct. In the State of Kansas 80 percent of our employers have fewer than 10 employees. But I do not know what percent have fewer than five employees or four or three. But it is pretty much as Senator Pryor indicated, there are a lot of small business.

Ms. BLAKELEY. This is something very fundamental. If you mandate small business at any level and, you know, the arbitrary numbers as far as who pays what portion, that money is coming out of that small business. It will impact jobs. It has no choice. It has no choice but to impact jobs.

The CHAIRMAN. I think we want to get those numbers from the Department of Commerce if we can.

Senator DOLE. And I want to ask Mr. Brennan too the 7.9 percent cap on payroll is not low enough in your opinion. When you limit it to 5 percent or 3 percent, does that make a difference?

Mr. BRENNAN. Well, first of all I would mention the 7.9 percent cap as proposed in the plan does not phase in for 6 to 8 years. So we have a period of time before we even deal with that.

Having said that, the lower the amount, the more workable it is. Our contribution is at about a 5 percent level right now.

Ms. BLAKELEY. Senator, I was just handed, 60 percent of businesses in the United States have fewer than five employees—60 percent of all businesses.

Senator DOLE. I would like to ask Mr. Sweeney, do you have any estimate on the value of the average annual health insurance benefit plan to reach AFL–CIO member?

Mr. SWEENEY. I am not sure of the average, Senator. But I would say that for family coverage it is probably in the range of $4,000.

Senator DOLE. $4,000 for a family of four. Now as I understand it, in the President's plan there are some groups based on existing contracts where labor would not be affected for 10 years; is that correct?

Mr. SWEENEY. Yes.

Senator DOLE. Then even after 10 years you would only be affected by any increase in supplemental benefits.

Mr. SWEENEY. The additional benefits.

Senator DOLE. So it does not really pose any problem for you?

Mr. SWEENEY. No. It is, we think, a very fair way of covering the existing health coverage. [Laughter.]

Senator DOLE. I think it is very shrewdly crafted politically, but I am not certain how that might affect people who are not union members or employers who do not have unions, and most do not have. But I can understand why you are so strong in support of the Clinton bill. I mean, it does not do anything.

If it did not do anything else to anybody else in America, there would be more support for it. [Laughter.]

Senator DOLE. Mr. Brennan?

Mr. BRENNAN. Senator, there is a matter of economics that I discussed before you came today. That is that the average retail employee produces about $1,765 in earnings to a corporation, where the average manufacturing employee contributes about $6,500. So the ratio is about 3.7 to 1.0.

As you begin to shift those costs into a low income industry, you have a major impact on jobs because we simply cannot afford it. In our case, it would more than double our health care costs.

The CHAIRMAN. That surely reflects return on capital.

Mr. BRENNAN. That is comprehended. I am talking about earnings. If you have no earnings, you have no return on capital.

The CHAIRMAN. Right.

Mr. BRENNAN. Yes, sir.

Senator DOLE. I want the record to reflect that I agree with Mr. Sweeney that they may have good benefit packages. But a lot of it is coming out of wages and I think that contradicts what Mr. Pollack had to say,at least in his charts.

But I was told today by someone in one of the major auto companies that in Michigan that the man who is, say, working for Ford Motor Company, his wife is working for some school district, she gets a cash bonus to use the Ford Motor Company plan. So it must be a pretty good plan. But it costs a lot. It costs a lot. It costs the company a lot, which means it costs the workers a lot in I assume lost wages. So there are going to be lost wages and there are going to be lost jobs.

We have Pizza Hut headquartered in our State. They have 185,000 part-time employees. I do not know how many are covered by their parents. I am not sure about the usual number of part-time workers in all the retail areas.

Mr. BRENNAN. It is about 50 percent.

Senator DOLE. Yes. So it makes it a big, big question. I would like to have all the numbers. You started to give us the description of the 38 million uninsured, because it has always been a figure that people throw around without even trying to break it down. I assume that——

Mr. BRENNAN. Well, I am using the same numbers that everyone else is.

Senator DOLE. Right.

Mr. BRENNAN. And then in terms of breaking that down, I was addressing the portability, pre-existing conditions and attempting to lay out what I believe needs to be addressed before we move forward aggressively with a mandate.

What I mentioned was that in terms of portability, portability is a huge number. It is anywhere from 25 to 30 percent of those uninsured are in the portability category. If we addressed that, we have already taken a large portion of a major problem and dealt with it. We then go to pre-existing conditions. We then go to the self-employed who do not get the deductions that corporations get and you begin to build this hierarchy, you begin to understand where the costs are and look at revenue and costs and determine how you address it.

In my view, that is the most intelligent way to approach it.

Senator DOLE. Well, you could take care of some of the rest of it with either vouchers or——

Mr. BRENNAN. Then you deal with the cost side of it.

Senator DOLE.—credits or whatever.

Mr. BRENNAN. That is correct.

Senator DOLE. To take care of other people not covered. I do not have any additional questions.

The CHAIRMAN. Thank you.

I would like to make a point, that the AFL–CIO has come before this committee and this Congress for more than a century now speaking not only with the interest of union members but indeed, the public at large. That is what John Sweeney is here to do.

Let us poll this panel. Non-portability, pre-existing conditions. Do you agree that we should get rid of them? Is there anyone that thinks otherwise?

Mr. BRENNAN. No. That should be dealt with absolutely.

Ms. BLAKELEY. We should definitely deal with them.

The CHAIRMAN. We would like to hear you say something on the record so we get it. Blakeley votes aye.

Ms. BLAKELEY. Aye.

Senator CHAFEE. Well, she wants portability, not get rid of it.

The CHAIRMAN. The problem is to resolve those problems.

Ms. BLAKELEY. Yes.

The CHAIRMAN. Brennan votes aye.

Mr. BRENNAN. I agree with that.

The CHAIRMAN. O'Flinn votes?

Mr. O'FLINN. Aye. May I say aye with a comment, Mr. Chairman? [Laughter.]

Senator DOLE. We are not allowed to do that.

The CHAIRMAN. No, we do not do that here. [Laughter.]

Mr. O'FLINN. I want to say it is a firm aye.

Mr. Pollack?

Mr. POLLACK. Aye.

The CHAIRMAN. And Mr. Sweeney?

Mr. SWEENEY. Aye.

The CHAIRMAN. Now there you are. How is that for harmony? See what you have done, Bob Dole.

Senator DOLE. Good work.

The CHAIRMAN. See what you have done.

Senator DOLE. We will pass that out today.

The CHAIRMAN. Senator Breaux, you are next.

Mr. SWEENEY. Can we take up the rest of the issues?

Senator BREAUX. Thank you, Mr. Chairman.

When I look at the chart, I see good news and bad news. The good news under the Health Security Act is that the percentage of income that an individual would pay for their insurance is only 3.9 percent of their income. The bad news is, they may not have any income.

I think that point was made today. The employer mandate in some areas is going to clearly result in loss of jobs. So it does not matter that you are only going to pay 3.9 percent of your income if you have no income. I think that really is something that this committee needs to look at.

The other point is that this chart does not show, for instance under Cooper Breaux, that that premium is 100 percent deductible.

To the family, if it is within the tax cap. So the chart, I think you can look at it in a number of different ways, and it is not accurate.

Let me ask, Mr. Brennan, your company, Montgomery Wards, has insurance for all of your employees. You compete against a number of smaller retailers in the country who do not have insurance for their employees. Why would you not be for an employer mandate?

It is clear that your premiums probably cost you a little higher because of all those competitors who do not provide insurance for their employees and they have a competitive advantage over you. But it would seem that you would be requiring all of your competitors to do what you do already.

Mr. BRENNAN. There are many other factors in terms of competition.

Senator BREAUX. I understand that. But this is one. Why would you not be interested in eliminating that?

Mr. BRENNAN. Well, first of all, to go back to my point earlier, I think that solving a problem like this with a mandate is tantamount to disaster. I think that we have to look at the economics of what it costs us to run our business, what our income is and how we can support our employees in terms of health care.

I think that to take a plan such as the Clinton plan, which is basically a rich plan and impose that across all businesses destroys the economics of business. So I am more concerned about how we deal with that issue than I am concerned about the small retailer versus the large retailer because I think that is the core issue here, even beyond the retail industry.

If we decide we take a Cadillac plan and we cross all businesses with that plan, then we are all going to be hurt and our number to your point earlier is anywhere from up to 500,000 to a million jobs—20 million employees in the industry and 5 percent is one million jobs. That is a major impact on the industry.

Senator BREAUX. I have no problems philosophically with a mandate if we get something for it. I am concerned that the negative factors outweigh the positive in the sense that what you are saying is that I have always felt we ought to reform the system before we start mandating it.

Mr. BRENNAN. Exactly.

Senator BREAUX. If we get the reforms in, let us see what else needs to be done after the reforms are in place. You say that implementation of an employer mandate would cause a massive disruption to the retail industry. As studies have estimated, up to one million jobs would be lost under an employer mandate. And for those people who lost their jobs the 3.9 percent of their income does not mean a lot for them if they do not have a job.

Mr. BRENNAN. That is exactly right. It is 3.9 percent of nothing. And the issue really is jobs.

Senator BREAUX. Let me ask you, Mr. O'Flinn, I think was it you who indicated that the point of ERIC's proposed framework for reform is a modified individual mandate to be accompanied by income-based subsidies? When you talk about a modified individual mandate, what are you talking about? Would you describe that for us?

Mr. O'FLINN. Senator, we think that in order to cover the uninsured population, 60 percent of which is less than 30 years old, you are going to have to resort to individual mandates because it is not merely a question of affordability.

You correctly pointed out that the percentages that Mr. Pollack describes, premium over total compensation, do not amount to much if you can improve them, but you lose your compensation or as Senator Chafee pointed out, if the denominator moves, too, the cost stays the same.

We pay 80 percent in our organizations, in most organizations, and we have a terrible problem in getting the people under 30 to buy what is offered to them, because the issue is more than affordability. These people do not generate claims equal to a community rated premium.

Senator BREAUX. So I guess what you are saying is, our plan tries to make it attractive—we try to do the insurance reforms, we try to do the purchasing cooperatives, we try to do a comprehensive plan. We try to do all things to make it more attractive for an individual to be able to afford to buy and want to buy. But you are saying that even with that you would probably have to have some type of an individual mandate?

Mr. O'FLINN. That is our experience. Our experience is that individual coverage at my company costs $18 a month.

Senator BREAUX. Why is that better than an employer mandate then in your opinion?

Mr. O'FLINN. The employer mandate does not work to achieve universal coverage because it is beyond a question of affordability. The question of affordability I think you have addressed. But our point would be that if you truly want to achieve universal coverage, you must have an individual mandate because people who are less than age 30, particularly people in the heaviest uninsured category, which is I think 20 to 24, do not believe there is justice in a community rated premium for them.

And frankly, I have a hard time arguing with that. Typically, the younger people generate the profit for the plan to pay the claims for the older people. So if you want them in the plan, you are going to have to mandate them in the plan.

The CHAIRMAN. But, Mr. O'Flinn, one of the rules of the U.S. Senate is never to trust anybody under 30. [Laughter.]

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman, very much.

Mr. O'Flinn, I am interested in what you say. And, of course, people under 30 think they are going to live forever and they do not see why they should get health insurance.

But then an 18 year old graduates from high school, has a little bit too much to drink and runs into a tree and is a paraplegic for the rest of their life. Then health insurance becomes a little bit more meaningful. Or two wonderful young people get married and have a kid and then some diabetes comes from somewhere in the family and all of a sudden insurance becomes a different matter.

I think listening to what Senator Dole is saying and having just listened to the conversation in the Senate as well as the conversa-

tion in this committee, is that we really do want universality of coverage. The Chairman wants it. The committee wants it. That is the talk that you hear that is building as we get closer to making a decision.

And each week that goes by, what people say becomes more important. We are coming out from behind our pulpits, a little bit from behind our theologies, our ideologies so to speak.

We are going to end up with universal coverage. That is something we can be very proud of. We are moving in that direction. I really believe that. I think you have asserted that whether it is an individual mandate as in the Chafee plan or the corporate mandate which is in the President's plan, one way or another we have to find a way to get everybody covered.

Universal coverage is important for a very good reason—that health insurance brings peace of mind and it adds a great deal to the quality of life.

Now I will ask a question of Ms. Blakeley and Mr. Brennan. I want to make a point. There is a lot of anecdotal studies that show that 3 million people are going to be thrown out of work or 1 million people are going to be thrown out of work.

After the Pepper Commission ended, I started a nonprofit corporation called the Alliance for Health Reform. We have had a series of hearings on what would be the employment effect of the mandate.

We have had studies. The woman who did the study that said there would be a loss of 3 million jobs could not come to the hearing because she was sick. But what was obvious in that report was that none of the aspects of the Clinton health plan were in the study—none of the subsidies—nothing. It was just as if you made up something.

And, in fact, our panelists—we had one from MIT who was liberal; and we had one from EBRI, which is the Employee Benefits Research Institute who was neutral; and one from the University of Alabama study who was conservative.

They all agreed that job loss through a mandate was a wash. They all agreed. They were surprised to agree. It was a wash and it ought to be dismissed as a significant factor in this debate.

Ms. Blakeley, you have health insurance, do you not?

Ms. BLAKELEY. Yes.

Senator ROCKEFELLER. And, Mr. Brennan, you have health insurance?

Mr. BRENNAN. Correct.

Senator ROCKEFELLER. I want you to explain to me why health insurance is important to each of you individually and to your families. It is a personal question, give me a personal answer.

Mr. BRENNAN. I would like to respond to one comment you made earlier if I can though, on the anecdotal information. There is a lot of it around today, obviously. But I would like to give you some empirical evidence of what has to be done.

Senator ROCKEFELLER. Could you answer my question first and then give me that?

Answer my question and let Ms. Blakeley answer it, then you can come back.

Mr. BRENNAN. All right, I will answer the question. But I would like to come back to my other point if I may. I think that the point that you made is an accurate point by far, that peace of mind is very important to all of us. I think that we need to understand we have coverage if we have a problem and I think that is a very significant issue to our employee base and that of the entire country.

I think at the same time there is a way to get at that and deal with it, other than the mandate.

Senator ROCKEFELLER. But you do think that everybody having health insurance is an important goal for this committee and for this Congress and for this country?

Mr. BRENNAN. I think that everyone should have access to health care coverage.

Senator ROCKEFELLER. And everybody should have health care coverage?

Mr. BRENNAN. I said everyone should have access to health care coverage.

Senator ROCKEFELLER. But there is a big difference there. You know, a poor person has access to it.

Mr. BRENNAN. I understand that. But I also understand that we have to get there in a logical way.

Senator ROCKEFELLER. Yes. But still you would like to see everybody having health care?

Mr. BRENNAN. It would be my desire to provide health care coverage for all of our associates. That is correct.

Senator ROCKEFELLER. Ms. Blakeley, why is health insurance important to you?

Ms. BLAKELEY. I provide health insurance. It is a business decision for me. I provide health insurance for my employees because I feel it gives me a competitive advantage over people that do not, because I can attract the right people. It is well worth the investment because I have happy, motivated people who want to stay at work for my company.

I invest a lot in the training in people that do my kind of work. We do very unusual work and we invest a lot in training. So I consider it very important from my business perspective. But I do not try to prejudge——

Senator ROCKEFELLER. You mean from your personal perspective, too. Right?

Ms. BLAKELEY. Absolutely. Sure. I am a small business owner. I do not do personal very often. I do business. You know, you kind of—[Laughter.]

When you have a small company, you live, eat and breathe it.

Senator ROCKEFELLER. But is it not also true when you have a small company that the people that you are likely to employ—I do not know where you come from, if you come from a State like I do, or Senator Daschle or Senator Breaux, you are likely to know all of the people in your company anyway. They are your neighbors. They are your friends. They are your relatives. You are likely to know them. So you have a more intimate relationship with them in the work place as well as in the community than in Xerox or in IBM.

Ms. BLAKELEY. Absolutely and I am very fortunate. Today I can provide a very good health care package for my people. When I first

started my company though, I had a very inexpensive basic policy because that is all I could afford. But those people were employed. They were working. And they were investing as well as I was in the growth of my company. And luckily, I made more right decisions than wrong decisions. So we grew.

I have been very fortunate. If that mandate had come into place 10 years ago, I would not be in business today because I did not have the cash to carry it. There is no way it would have worked. So this is why I keep going back to the mandate issue.

My company will survive a mandate because it is old enough and I have enough cash reserves. I would survive that, even the additional cost. It would impact us because you cannot—when you are small business—think about this for a minute—and if you have an unexpected expense, particularly a—take two businesses, OK.

One right beside each other that had an exact same amount of revenue. They have the exact same number of employees. One of them is 1 year old and one of them is 10 years old. That one 1-year-old is still putting in for plant and equipment, is still out there scrambling trying to get a reputation made, spending money on different types of things.

That 1 year old company most likely will not survive that mandate because they do not have the cash to survive that. The older company probably could. What fascinates me is when, I do not understand where you say the job loss is a wash. How can you have a wash in job loss? You have companies who are going to go out of business and you are going to have people out of work. Where are these new wash-out jobs coming from?

Senator ROCKEFELLER. Well, just to answer your question, there would be 850,000 new jobs in home health care alone.

Ms. BLAKELEY. So you are going to lose jobs in existing small businesses to create health care jobs?

Senator ROCKEFELLER. No, that is just one of the effects. Today there are a lot of small businesses that go out of business, right? Because of the cost of health insurance or because of the competition or because of the normal economic climate businesses go out of business because of a variety of reasons.

Ms. BLAKELEY. Yes.

Mr. POLLACK. And, Senator, because some businesses are now picking up the costs for those businesses that do not provide coverage, they will save that cost when everyone is insured. That will help them create jobs.

Senator ROCKEFELLER. Yes, about $12 billion.

Mr. SWEENEY. We have had these discussions on the loss of jobs in other hearings, mostly focused on the increase in minimum wage. And study after study has shown that there has been no loss of jobs.

With regards to health care, the State of Hawaii imposed an employer mandate in 1974,I believe. Since then employment in the State has increased substantially over the past several years.

The CHAIRMAN. I think the point is that with the cost shifting, that we now have, there are is room to increase and profitability of existing firms goes up, so employment is very likely to expand. I simply make the point, without knowing the net effect on employment.

Mr. Brennan, just a brief comment and then Senator Danforth.

Mr. BRENNAN. Okay. The point I would make on minimum wage, that a 50-percent increase in minimum wage is substantially different than the doubling of health care costs. I would also say to you that if you take the retail industry, if people in this room put their hand up and said whoever worked in the retail industry, it is a port of entry and it is a safety net for people between jobs.

I think you have to look again at the employment and the economics. Thank you.

The CHAIRMAN. A fair point.

Senator Rockefeller?

Senator ROCKEFELLER. No, sir. My time is up. I thank you for your generosity, sir.

The CHAIRMAN. Senator Danforth?

Senator DANFORTH. I think that the employer mandate is a dead issue. I just do not think there is any chance at all that we are going to put enough votes together to pass an employer mandate. But I would like to address the question at the risk of maybe beating a dead horse.

My understanding of the panel that appeared before the Alliance for Health Reform is that there would be at least for a time a disruption in employment, in jobs. And there would have to be, it would seem to me. It would not be just a smooth transition. There would have to be a disruption if we placed a new and very significant economic mandate on employers.

But I want to get to the longer term because in the longer term I think most people say, well, employers do not pay taxes somebody else does, corporations and——

The CHAIRMAN. Employers do not pay health care costs.

Senator DANFORTH. Or taxes when we have taxes or mandates or whatever, that it does over at least some time work its way out into the system. And the last panel—and I am sorry I had to be on the floor of the Senate during the appearance of the last panel—but it is my understanding that the testimony of the last panel was that even if there were an employer mandate the effect of that would be that about 88 percent of the cost would be passed on to the employees in the form of reduced wages.

The CHAIRMAN. That was the number.

Senator DANFORTH. And the remainder in the form of increased costs, increased prices. So that there is an adjustment that is made, and the point being that people end up paying the cost.

So if it is an employer mandate, people end up paying the cost. If it is an employee mandate, people end up paying the cost. Now, our objective it seems to me is, that if people end up paying the cost somehow we have to figure out how to mitigate that blow by providing some sort of subsidy for people.

That is why I think an employee mandate, an individual mandate, rather than employer mandate is a much better way of providing real assistance subsidizing real people. I also think it is a better way of phasing in whatever we are going to do.

I mean, if we are concerned about the cost and we want to have some sort of phase-in, it seems to me that the best way to do it is to phase it in as a percentage of poverty so that lower income people are subsidized and then if the program works out and the

cost savings are there, then we subsidize higher income people and we go on up.

But wherein am I wrong in this analysis? I mean, I do not understand how we can effectively subsidize real people who are going to pay the real cost of whatever we are going to do unless we have the mandate going to real people and we assist real people in paying that cost.

If you have a program where 80 percent of the cost is paid by employers, then we subsidize them on the basis of the size of the employer or the economic health of the employer. There is a lot of slippage between helping, let us say, small employers and large employers who employ a large number of low-income people. I mean it just does not seem to me to be something that works.

Furthermore, with respect to any incentives for participating in cost containment, if individuals—real living and breathing people in charge of their own health—are the ones who are participating in the program, it seems to me that there is a much greater incentive for cost containment than if you have businesses being mandated up to 80 percent with a cap on how much they have to pay and with the decisions basically being out of their hands.

So I do not understand either from a cost containment standpoint or from a how do we help poor people standpoint how the employer mandate advances the cause at all.

Mr. POLLACK. Senator, may I respond to that? Everything you said, with the exception of the first comment about the enactment of an employer mandate being impossible, I would subscribe to from a theoretical standpoint. I agree with you that an individual mandate does allow greater targeting of resources. It actually can do that.

I agree with you that, theoretically, an individual mandate can work. I do not think that is the issue. The concern I am trying to raise is that if you go in that direction, then Congress has got to step up to the plate with respect to adequate subsidies to make that affordable for families and individuals.

I am suggesting to you, with all due deference to Senator Chafee and the other approaches, that I do not believe the subsidy schemes in the current proposals on an individual-based mandate system would do the job because they leave far too much for individuals and families to pay out of pocket. That is the point of these charts.

So it remains unaffordable for them. If, on the other hand, you feel you can come up with the revenues to achieve that, we have no argument whatsoever. My concern is that you may not come up with those revenues.

Senator DANFORTH. Well, Mr. Pollack, my argument is—and I am sorry to say I have not had an opportunity to study your charts—but for whatever money we come up with, whatever we come up with by way of subsidies, it is more efficient to subsidize people than it is to subsidize organizations on some basis other than the income level of people.

Mr. POLLACK. I happen to agree with that. My concern is that you are not going to come up with an adequate subsidization so that the goal of universal coverage is not going to be met. If you want to go that direction, bless you. Do it. But then come up with

sufficient revenues to make sure that these kinds of burdens are not going to be unaffordable burdens for individuals and families.

Senator ROCKEFELLER. Would the Senator yield?

Senator DANFORTH. Yes. I would like to hear from the panel, too.

Senator ROCKEFELLER. I am sorry.

Senator DANFORTH. But I would be happy to.

Mr. SWEENEY. If I may.

he CHAIRMAN. Well, can we just go across the panel? Mr. Sweeney?

Mr. SWEENEY. Senator, we feel that with an individual mandate more people would get left out of the system. The question is, what do you do with the whole process that has developed with employment based health insurance now for those who do have it and how do you enforce the individual mandate?

The CHAIRMAN. That is a perfectly fair proposition. Mr. O'Flinn?

Mr. O'FLINN. Senator, ERIC is in agreement with your position that an individual mandate is the best route to universal coverage because, again, our membership sponsors very good, among the best benefit plans in the United States and we typically do pay more than 80 percent of the coverage.

Our experience is that we have many of the same people who are in the nation's uncovered population in our uncovered population. In other words, affordability does not equal universal coverage and this is because of the fact that this group of young people who comprise 60 percent of the 38 million—about 11 million children under the age of 18 and about 12 million between the age of 18 and 29, this group perceives that they do not generate claims equal to a community rated premium, and they are correct.

And it is a dilemma that we very much need the people in that age category who are contributing to the system to continue to contribute and yet we cannot do justice, so to speak, for the people who are uncovered.

The only way to get that group of people to buy coverage is to recognize that they have to participate in the system and mandate it by law. The employer mandate will not only not achieve it, but it will aggravate the inequity as Ms. Blakeley and her associates in small businesses take their calculator out and add up their premiums for their young population and realize that they are paying much more in premiums than their employees are generating in claims.

They are going to ask, who is it that we are paying for, because it is certainly not our employees. That is a terrible problem with the employer mandate. The unfortunate thing about universal coverage as a goal is that I really wonder how many of those 38 million people will thank you for that coverage.

The CHAIRMAN. Oh, Mr. O'Flinn, we know all about that. [Laughter.]

Very few. Very few, sir.

Mr. Brennan?

Mr. BRENNAN. Well, Senator, I think I have made my point enough times on employer mandates today. I think what troubles me is, we discuss mandates, subsidies, carve outs, phase-ins. There are all kinds of nomenclature around Washington on all these issues. I guess I am back to ground zero in terms of examining

where the costs are, where the needs are and then intelligently following that process.

The CHAIRMAN. Thank you.

Ms. Blakeley?

Ms. BLAKELEY. I am sure you know I am going to agree with the Senator's comments. From what I understand NFIB has surveyed this issue on individual mandates and they would not be opposed by the majority of the membership of NFIB.

On a personal note, I agree with a lot of the statements made is that an individual mandate would be a good thing. That is my personal opinion. One of the other things it does, and this fascinates me—no one has brought this up—so many people have the idea that health care is free and you have a lot of abuse of the system.

I think we have created that by having health care provided.

The CHAIRMAN. We have heard a lot about that on a lot of other occasions.

Ms. BLAKELEY. I am sure you have. But what that would do though is bring people back into a little bit more self-responsibility.

The CHAIRMAN. Senator Rockefeller, you wanted to ask something.

Senator ROCKEFELLER. Yes. Actually, and if Senator Danforth does not mind also to share this with Ms. Blakeley. On the individual mandate, one of the concerns is that the family might take that government-allowed tax credit money and not use it for health care. They might use it for a pair of shoes that their kids need in order to be able to go to school or if the side of the house was knocked down by a tree and they had to get that repaired.

So under any individual mandate would the money be used for health care and, in fact, would be set aside and only could be used for health care?

Senator DANFORTH. Senator Chafee's idea that I have latched onto has a voucher. It could not be used for anything else.

Senator ROCKEFELLER. It could not be used for anything else.

Senator CHAFEE. I have one more question if I might. I am not trying to interrupt this exchange, but when they are through.

The CHAIRMAN. Well, if you would please. Then the last word from the Senator from Rhode Island. Are you finished?

Senator ROCKEFELLER. Go ahead.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. I would like to ask this of Mr. O'Flinn and Mr. Brennan, particularly Mr. O'Flinn representing ERIC. Do some of your companies currently pay more than 7.9 percent of payroll for health insurance?

Mr. O'FLINN. Yes.

Senator CHAFEE. All right, and I have understood that some of them may be paying as much as 11 percent of payroll?

Mr. O'FLINN. Well, if you count retiree coverage, you will have to raise that to 20 percent.

Senator CHAFEE. So if that is true, under the administration's proposal—and Senator Rockefeller knows the administration's proposal better than I do, and correct me if I am wrong—if there is a 7.9 percent cap, and you are paying 11 percent, why is there not a tremendous incentive for the company to just send a check for 7.9

percent of payroll to the alliance and say forget it. I am not getting involved anymore with quality or trying to beat down costs. Here is your 7.9 percent, let the Federal Government pick up the balance.

Mr. O'FLINN. Were the administration's proposal to pass without change, Senator, we have polled our membership and the overwhelming majority say they would not form a corporate alliance. They would do exactly what you said.

The corporate alliance does not offer them any control over, or sufficient control over, their health care costs in their opinion and they would have no choice but to join the regional alliance.

Senator CHAFEE. But I am more interested in the 7.9 percent cap. It seems to me that the 7.9 percent cap would, if the administration's plan passed intact, would help many of your members. Would it not?

Mr. O'FLINN. Oh, it would help if it held, yes.

Senator CHAFEE. Well, what do you mean by held?

The CHAIRMAN. If we can make it 8.9 the next year.

Senator CHAFEE. Oh.

Mr. O'FLINN. Exactly.

Senator CHAFEE. So therefore this could potentially be a very, very expensive program for U.S. Government, if the 7.9 percent held.

Mr. O'FLINN. That is the way we see it Senator, yes.

Senator CHAFEE. Am I missing something, Senator Rockefeller?

Senator ROCKEFELLER. No. I think it would be interesting to hear Ron Pollack on that, because that is exactly what the President's plan says, that 7.9 is the maximum unless you get up to 5,000 and people decide to opt out and self-insure.

I would be interested in Ron Pollack's answer whether this is a big government program. That clearly is what the President's program says and he has accounted for the figures. I do not think CBO indicated in any way that that was a specific problem.

Mr. POLLACK. That is correct.

Senator CHAFEE. It seems to me, Mr.—am I interrupting?

Senator ROCKEFELLER. No, sir.

The CHAIRMAN. Mr. Brennan did want to say something.

Mr. BRENNAN. Senator, you addressed that question to both of us. May I respond?

Senator CHAFEE. Yes.

Mr. BRENNAN. Number one, the 7.9 percent cap will be phased in as you know over a relatively long period of time. I do not want to dismiss that because it is a major issue.

But number two, in the retail industry the average rate is far below 7.9 percent because we are dealing with a high number of people moving in and out of the work force and, therefore, it would be detrimental to us.

Number three, any mandated plan that starts at a certain level will probably go up and not down. So we have three issues. One is phase-in. The second is 7.9 is far above the retail contribution. And number three, how do you control costs going forward?

Senator CHAFEE. Well, I think you made that point before and I think it is a very valid one that we all ought to bear in mind.

Under the employer mandate, the employer is locked in at 80 percent of a cost, which the employer does not know where it is going.

Mr. BRENNAN. It cannot go down; it can only go up.

Senator CHAFEE. No, 80 percent of what—80 percent of health care costs. First of all, somebody else is going to set the package under the administration's plan. So, therefore, you are hooked for wherever this sleigh ride goes.

Mr. POLLACK. But there are limitations in the President's plan as to where premiums go. That is part and parcel of that package. So you do have predictability in terms of——

Senator CHAFEE. You mean because the government controls the premium?

Mr. POLLACK. Because there are caps in the way the premiums are allowed to grow. That is part of that same architecture.

Mr. SWEENEY. And you cannot look at the cap on costs if you do not look on the cost controls. And you cannot take the Montgomery Ward experience in terms of what they are paying for health care, you have to look at the national numbers.

Mr. POLLACK. But, you know, Senator, I am really bemused that the plan is being hit from both sides in contradictory ways here. On the one hand, we are saying it is too great a burden on businesses and we need to protect businesses. And on the other hand, we are saying since there are a whole bunch of businesses that are going to be better off, it is going to be too great a burden on government to help these businesses.

You know, you cannot win under either proposition from the way I am hearing it.

Senator CHAFEE. Let me just finish one final question. Mr. O'Flinn, it seems to me that there are two factors that would make your membership leap on the administration's plan with joy. One is this cap that is going to—and I suppose you have suspicion about government sticking by its promises—but let us assume the 7.9 percent stays.

The other is that there is going to be this bonanza of all your early retirees having 80 percent of their health insurance paid by the taxpayer. Now is that a wonderful thing for your folks?

Mr. O'FLINN. Yes, it is. It would be a wonderful thing if it came to pass and the——

The CHAIRMAN. Mr. O'Flinn, are you indicating skepticism?

Mr. O'FLINN. We are skeptical that that provision will last, yes, Mr. Chairman.

The CHAIRMAN. I must say I am amazed. [Laughter.]

Mr. O'FLINN. But on a net basis, we believe the administration's proposal in its current form is underfunded and would require additional funding which it appears would come from employers. It would come from the employer apparatus.

Mr. Pollack is right, some people would be hurt immediately by the President's proposal, by going up to 7.9; others would be helped tremendously. But on a net basis——

Mr. POLLACK. You are not required to go up to 7.9 percent; it is a limitation. Please, let us make sure we understand the President's proposal accurately.

Mr. O'FLINN. That is a good point, Mr. Pollack. It is a limitation that depends on the success of the cost control mechanism.

Senator ROCKEFELLER. No, it is a limitation which depends on the size of the business and the number of employees in the business and the salaries that those——

Senator CHAFEE. I am not involved with this and I want to thank the panel very much. Unfortunately, I have another appointment. Thank you.

The CHAIRMAN. I very much want to thank each of you. You have been very helpful, very forthcoming. You see we are struggling with matters here and we are making some progress. You have a Finance Committee that has a clear, strong majority for universal coverage and that is where I think Claude Pepper would be very pleased to see us today.

Senator ROCKEFELLER. Mr. Chairman, could I just add to that, I was not at the last hearing because I was on the floor with Jack Danforth.

The CHAIRMAN. Sure.

Senator ROCKEFELLER. But my understanding was that with the exception of Stuart somebody from the Heritage Foundation——

The CHAIRMAN. Stuart Butler.

Senator ROCKEFELLER. Stuart Butler. That all of that panel, the previous panel, came out very strongly for universal coverage.

The CHAIRMAN. Oh, yes, emphatically. And I do not know that Stuart Butler opposed.

Senator ROCKEFELLER. So all of the panel then came out for that.

The CHAIRMAN. Yes.

Senator ROCKEFELLER. So that this whole concept—my closing thought, would be that Ms. Blakeley and Mr. Brennan and Mr. O'Flinn, rather than trying to crush concepts that the Congress is now considering—I mean one of the things that people do is if there is an idea out there, just as soon as it is born they just put their thumb on it and squish it so it does not get any bigger.

But rather than do that, if you make the assumption that Republicans and Democrats are dead serious about universality of coverage—everything has to be phased in. We understand that. The Pepper Commission phased coverage, too. But if we are absolutely serious about doing that—and Ms. Blakeley, you and Mr. Brennan maybe in particular—rather than saying this cannot work, all these people are going out of business, we are against this, we are against that, try instead to come up with some ideas that would be helpful to a committee and to a Congress which is clearly moving, as the American people already are, strongly toward a bill that will have universal coverage.

Mr. BRENNAN. We would be happy to do that.

Ms. BLAKELEY. I do not know of anybody that does not support universal coverage.

The CHAIRMAN. There you are. There you are. That is the spirit. This meeting is adjourned. With great thanks.

[Whereupon, at 12:26 p.m., the hearing in the above-entitled matter was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF ANN BLAKELEY

Good morning. My name is Ann Blakeley and I am the president of Earth Resources Corporation of Ocoee, Florida. I employ 25 people, and my company specializes in the management of particularly hazardous materials. Today, I am testifying on behalf of the National Federation of Independent Business (NFIB). NFIB is the nation's largest small business advocacy organization representing more than 600,000 small business owners in all fifty states. The typical NFIB member has five to eight employees, and grosses $250,000 in annual sales. NFIB sets its legislative positions and priorities based upon regular surveys of its membership.

I want to thank you, Mr. Chairman, for inviting NFIB to testify before this committee. I want to commend you for dedicating this hearing to proposals that would require employers to pay for a comprehensive health benefits package for all employees. No issue Congress will consider for years to come will have a greater impact on Main Street small businesses and the people they employ than the health insurance employer mandate. No issue has a greater capacity to challenge and possibly reverse what NFIB sees as the emerging consensus in Washington and around the country about how to reform health care in America and how small business should be treated in that reform effort.

This testimony will evaluate the employer mandate both as a general policy matter and also specific forms of the mandate. The most visible employer mandate proposal to date has been the president's. I will spend considerable time focusing on the mandate in the Health Security Act because it provides a constructive example of how an 80% employer mandate, the most commonly proposed form of mandate by its supporters, would affect small business owners and their employees. The Health Security Act also sheds light on the degree to which subsidies can alter the impact of such a mandate. My statement will also examine the impact on small firms of other employer mandate proposals.

THREE KEY QUESTIONS

Few public policy debates in the nation's history have been more complex than the national debate now taking place over health care reform. As suggested above, the debate over the employer mandate can quickly be distilled down to three basic questions:

(1) What impact would the employer mandate in the President's Health Security Act have on small businesses and the people employed by them?
(2) How would the proposed small business subsidies and payroll caps in the Health Security Act alter that impact?
(3) How would other proposed forms of health insurance employer mandates affect small businesses and the people employed by them?

Based upon nearly a decade of research and surveys on small business and health insurance, my testimony will attempt to answer each of these questions. First, it is important to provide some context about the conditions in which small business owners currently find themselves when it comes to purchasing health insurance for their employees.

HEALTH CARE REFORM FOR SMALL BUSINESS: DR. JEKYLL AND MR. HYDE

Whether you call it a crisis or a problem, small business owners are clearly the victims of the many flaws in the current health insurance market. They often pay

approximately 30% more than larger companies for similar benefits because of administrative costs. They often pay an additional 30% more in premiums because of costly state mandates for specific types of insurance coverage, which prevent small business owners from shopping for only the basic care that their employees might prefer. Larger firms that self insure, by contrast, are not subject to these costly mandates. In addition, a small firm is far more likely than others to feel the painful brunt—both economic and emotional—of the preexisting condition exclusion or, when an employee gets sick, the 20% to 300% premium hike, or the sudden cancellation of insurance. Insurance companies are much more likely to require exclusions, raise premiums or cancel policies to shield themselves from risk when insuring a small firm rather than a large business.

Small business owners who provide insurance for their employees, or who are attempting to, are currently stuck in this dismal situation just described. They have nowhere else to go. Their firms are usually not large enough to self insure and they often do not have access to managed care arrangements. In NFIB surveys, small business owners have said that health insurance is a benefit they *want* to offer—it gives them a competitive advantage in a labor intensive sector of the economy—but they often find its cost prohibitive or they can't find it at all.

All of this accounts for a trend in NFIB Foundation surveys that began in 1986. In that year, small business owners for the first time identified the cost of health insurance as their number one problem. That trend has continued ever since, with the cost of health insurance proving to be twice as critical a problem as the number two problem in the survey, federal taxes on business income.

For all of these reasons, health care reform has over the last half dozen years become NFIB's most important legislative priority. We have said for many years that the status quo in health care is unacceptable. But NFIB and the small business community are also keenly aware that health insurance reform has a "Dr. Jekyll and Mr. Hyde" character about it. Either small business owners will be able to continue to thrive and produce the majority of new jobs in this country through meaningful reform, or they will be required to pay substantial new costs that many of the smallest firms cannot afford. Unfortunately, the employer mandate in the Health Security Act and other forms of it fall into the latter category. The mandate would result in job loss in the smallest, newest, most marginal firms in the economy. The explanation of why this will occur can be found in the answers to the three questions previously posed.

1. What impact would the employer mandate in the Health Security Act have on small business?

THE IMPACT OF PAYROLL TAXES

Title I of the Health Security Act would enact into law the idea that all Americans are entitled to a comprehensive set of health benefits which President Clinton has said is akin to that offered by Fortune 500 companies. Title I also places into law the requirement that all firms must pay for 80% of this Fortune 500 package for all employees, including Medicare recipients, and pro-rated payments for part-time and seasonal workers.

Title VI of the bill stipulates that almost all employers must fulfill this obligation by paying a specific percentage of payroll to Regional HealthAlliances, which, in the form proposed by the Administration, represent "agents of the federal government" according to the Congressional Budget Office. These mandatory payroll based premiums are a huge, new payroll tax levied to pay for 60% of the proposed new health care system.

With all due respect to the Congressional Budget Office, small business owners did not wait for the CBO announcement on whether the mandate is a tax or a premium. Small business owners know this is a tax increase. They know that the mandate would fund an entitlement created, managed, and regulated by the federal government, no different from Social Security, Medicare, Medicaid, or unemployment insurance. They know they would have to pay a percentage of payroll for this entitlement and withhold a portion of their employees' wages for the program, just like other government programs. They know that any effort they undertake to provide health insurance differently, less expensively, or perhaps not at all would be met by audits and penalties, both civil and criminal.

The question of whether the employer mandate is a payroll tax or a premium is not merely a game of words, as some have suggested, nor is it just a question of precedents in federal budget practices. It is important because it clearly shows that the employer mandate, regardless of its official label, has every characteristic of the

kind of mandatory payment that is most damaging to a small firm and the jobs it creates: it is a payroll tax.

Payroll taxes must be paid regardless of the financial health of a business. For small businesses, most of which survive not on profitability but cash flow, this is a particularly dangerous threat This problem is acute in new businesses, which create one in three new jobs in the U.S., because a new payroll tax is an additional fixed cost on those businesses every time they want to grow and hire new employees. Payroll taxes assessed to pay for mandatory benefits give small business owners a new cost over which they have no control, limiting their ability to provide the best possible compensation package for each individual firm's survival and based on employees' needs. And because most small firms are labor intensive, particularly in the retail and service sector, small firms take a disproportionate hit from a payroll based tax. Such taxes create incentives for buying machines and paying overtime (instead if hiring new employees) and disincentives for keeping existing employees. This is exactly the small business atmosphere the employer mandate would create.

Debunking A Misperception

Some have argued that, despite the damaging nature of payroll based taxes, the employer mandate in the Health Security Act would not hurt small firms because, as President Clinton said during his State of the Union Address, most small businesses provide health insurance for their employees already. This is simply not true. This lingering misperception skews the health care debate and created additional fallacies about how many firms would see their costs go up under the Clinton plan. Because the Health Security Act imposes at least a 3.5% payroll cost increase to all firms that do not currently provide health insurance, understanding the demographics of the employer community and what firms do or do not provide health insurance is crucial to this debate.

Based on data from the Census Bureau, the Congressional Budget Office, the U.S. Small Business Administration, the Health Insurance Association of America (HIAA), and others, between 40 and 45 percent of employers provide some level of health insurance coverage today. How is it possible that a substantial majority of Americans obtain health insurance through the workplace yet a minority of employers provide insurance for their employees? The answer to this question can be found by walking down Main Street in most congressional districts in this country. Sixty percent of employers in the United States have fewer than five employees. That accounts for three million of our employers. In this group, 74% do not provide health insurance for their employees. NFIB surveys indicate that in most cases, as alluded to earlier, the sole determinant for not doing so is cost. Coincidentally, these are the people getting the worst deal in the insurance market.

PERCENT OF FIRMS THAT DO AND DO NOT OFFER HEALTH INSURANCE (HIAA, 1989)

Firm size	Offer	Do not offer
Fewer than 5 employees	26	74
5–9 employees	54	46
10–24 employees	72	28
25–49 employees	90	10
50–99 employees	97	3
100 or more employees	99	1
Total	[1] 42	58

[1] A 1992 HIAA study adjusted this figure to 40%.

The employer mandate precludes a health reform approach that makes it possible for these firms to respond to a reformed health insurance market. Instead, it immediately and disproportionately raises the payroll costs of these firms, in the case of the Clinton plan, by 3.5% to 7.9% of payroll, and ultimately makes them responsible for 80% of a very rich standard benefits package.

While small business in general would be hit hard by the employer mandate, minority and women owned small businesses will be hit even harder. These firms tend to be the smallest of our businesses. Minority owned businesses represent approximately 10% of all businesses, but only account for 3.9% of business receipts. In addition, of those minority owned firms that have employees, the average number of employees is 3.1. Women owned firms tend to be in the retail and service sector, which often tend to be small businesses.

Lewin-VHI, the health care consulting firm whose report on the Health Security Act the Clinton Administration embraced, has estimated that employers that do not

currently provide health insurance for their employees would have $29.3 billion in increased payroll costs in the first year the law would be fully in effect. Between 1994 and the year 2000, firms that do not now provide insurance would have $107 billion in new payroll costs. These figures take into account a small business subsidy. Because of the demographics mentioned earlier, the smallest firms in the economy would bear a disproportionate share of this cost

What would these firms with fewer than five employees do? How will they react to a new payroll tax? One option is to raise prices. But a small firm in an extremely price sensitive market could lose a significant customer base and might consider that committing suicide, and would choose to avoid that option. Another option is to reduce employee wages to cover the new payroll cost, but this cannot be done if the worker is earning the minimum wage. A third option is to let one or more employees go and limit hiring to the greatest extent possible. NFIB believes that the third option is the most likely to occur. In a September 1993 Gallup survey done for NFIB, 31% of small business owners said they would have to reduce the number of employees in their firm with even a 3.5% increase in payroll costs. Low wage workers, for reasons mentioned here, will be the first to go, severing the first step on the economic ladder for the working poor.

What about firms that do currently insure? The Lewin-VHI study estimates that nearly half of them would pay more for health insurance under the Clinton plan. The study says that firms that do currently provide insurance will net $400 million in savings by 1998. But this figure relies on $42 billion in savings from two forms of government intervention and spending that we believe are not likely to last over time given political pressures and financial constraints: premium caps and payroll caps. This means that most firms that would save money under the Clinton plan would be relying on a government subsidy or price controls, items over which they would have no control, to keep their costs down.

If a small firm already provides insurance for its employees, what would explain its health care costs rising under an employer mandate? Under the Clinton plan, a restaurant that provides health insurance for its full time cooks and managers but not its high turnover part time staff would likely spend more on health insurance. A contractor who provides health benefits for his secretary and his one full time worker but hires additional employees for the summer months, would likely spend more on health insurance. A growing computer firm that provides insurance for employees, who have an average wage of over $24,000, and has managed to keep its health care costs low cough a basic benefits package and high employee cost sharing would likely see its health insurance costs go up.

Whether a small firm provides health insurance or not, there are certain concerns about the employer mandate that all small firms will undoubtedly have in common. One is the wave of paperwork that employers would have to submit to Regional Alliances to prove compliance with the law and calculate payments, which would be a hidden payroll tax on employers. Second, employers are deeply concerned about a standard benefits package that sets Fortune 500 coverage as the minimum standard for health insurance. The Lewin study estimates that the annual per employee cost of the comprehensive benefits package in the Health Security Act would be between $5,000 and $6,000, 18% higher than Administration estimates. CBO said Administration premium estimates were off by 15%:

GROWING AGREEMENT ON THE EMPLOYER MANDATE

All of the problems cited in this testimony regarding the employer mandate contribute to the near unanimity among the American people, congressional leaders, economists, and even proponents of the mandate in the White House that it would result in job loss and prove damaging to small business:

- **Public Opinion.** 64% of Americans are concerned that the Health Security Act will cause employers to eliminate jobs, and 73% of Americans believe the plan would hurt small business. (*Washington Post,* 10/12/93)
- **Congress.** Congressional leaders in both parties have expressed deep reservations about the impact the mandate would have on small firms. Typical of such sentiment are the comments of Senate Small Business Committee Chairman Dale Bumpers who said on December 9th of last year: "There are literally hundreds of thousands of small business people in this country that might have to close their doors under the President's [health care] proposal. That is unacceptable."
- **The White House.** The Council of Economic Advisors acknowledged that 600,000 jobs could be lost under the President's plan. The small business subsidy plan is in and of itself an acknowledgement of the burden that would be placed on small firms by the mandate.

- **Economists.** A 1000 member survey of the American Economics Association in June 1993 indicated that 80% of the economists interviewed projected a decrease in employment among all employees as the result of requiring employers to provide health benefits to low wage employees.

Another study, recently released by the Employment Policies Institute (EPI), concluded that the Clinton employer mandate would result in 780,000 to 2.1 million jobs lost. EPI studies have indicated that the job loss resulting from requiring employers to pay for worker's health insurance expenses would be concentrated in just a few industries: restaurants, retail trade, and agriculture. Other industries that will see disproportionate job loss are construction, repair services, personal services and private household services.

A CONSAD Research Corporation study conducted in May 1993 found that three leading health care reform plans requiring employer mandates could impact 7.5 million to 18 million jobs in terms of reduced wages, reduction of other benefits, and potential cuts in hours worked. Job loss estimates ranged from 400,000 to over 1 million.

- **Small business owners.** As mentioned previously, in a survey of NFIB members taken by the Gallup organization last September, 31% of respondents said they would have to lay off workers if they had a 3.5% increase in payroll, and 38% said they would have to do so if their payroll costs went up 8%. Eighty-four percent of NFIB members said they opposed the employer mandate in the same survey, and a plurality said their opposition would grow stronger if there were a government subsidy to defray the cost for small, low wage firms. A majority of NFIB members currently provide health insurance for their employees (while only a minority of the overall small business population does, as discussed earlier), and they firmly oppose the employer mandate in the Clinton plan and variations of it.
- **Proof from abroad.** Europe is suffering from double-digit unemployment levels in part due to the fact that some countries have raised the benefits threshold for creating a job to a point where it matches what an employer can expect to pay in straight wages.

Some will argue that this growing consensus on the problems associated with the employer mandate is questionable because it does not adequately take into consideration the ability of small business subsidies to blunt the impact. This leads to the second key question of the employer mandate:

2. How does the proposed small business subsidy and payroll caps alter the impact of the employer mandate?

The President's proposal contains an elaborate small business subsidy scheme. The question of such a subsidy's effectiveness must be considered in two ways: short term and long term. Based upon NFIB's careful analysis of the Health Security Act, in neither case is the outlook bright. Section 6123 of the bill outlines the small business subsidy scheme through which the required health premium costs for small firms (under 75 employees) would be limited to 3.5% to 7.9% of payroll. The federal government would pick up the rest While NFIB appreciates this recognition that some small firms simply cannot afford to pay 80% of a government mandated "Fortune 500" health plan, these subsidies and payroll caps have so many weaknesses that small business owners view them as unreliable undesirable and under-financed.

SHORT TERM

In the short term, NFIB estimates that about three of four employers in the U.S. would have increased health care costs under the Health Security Act—even with subsidies fully financed. This figure is based upon the employer demographics and the Lewin-VHI study cited earlier. Again the lion's share of these costs will be borne by the very smallest firms in the economy.

An additional short term problem is that there are already mechanisms in the Clinton plan that would raise an employers costs over and above the 3.5% to 7.9% payroll caps that the bill guarantees. For example, a December 21,1993 Ways and Means Committee news release stated, "the premiums paid by employers and individuals would include additional assessments to cover the costs of certain Federally financed programs, such as academic health centers and graduate medical education, alliance administrative costs, and (premium) collection shortfalls (sections 6101, 6107, 6125, 1352, 1353 of the Act)." It is NFIB's view that these additional assessments undermine the payroll caps and could cause health bare costs to skyrocket, to the detriment of small Firms.

LONG TERM

There are several reasons to believe the small business subsidy is unreliable over the long haul and will be phased out over time:

(1) The percentages of payroll at which mandated health care costs are capped would always be subject to change. In fact, since the first unveiling of the President's plan, they have changed at least two times.

Example: Mr. Smith owns a landscaping company and employs 26 people who on average make $15,000 a year. When the first draft of the President's plan was released on September 7, 1993 his health care costs were capped at 3.8% of payroll. But what happened when concerns were raised that the health bill was not paid for? On October 4, 1993 a new subsidy table came out which would have raised Mr. Smith's cap to 4.4% of payroll (*BNA's Daily Health Care Report*). When the Health Security Act was finally submitted to Congress in November 1993, Mr. Smith's payroll cap rose again to 5.3% of payroll. In these two changes, Mr. Smith's already considerable mandated health care costs rose $5,850 per year. This process would only be magnified if the employer mandate were law and political and fiscal pressures mounted. Because of financing problems, the payroll caps appear to be made of Swiss cheese.

(2) While the bill "entitles" certain firms to payroll caps based on their size and average wage, it places a cap on the amount of funds that would be available for this entitlement. This means that if estimates for the cost of this entitlement are off, the "caps" of 3.5% to 7.9% are meaningless.

There is every reason to believe that the Administration estimates will be off. Neither the Bureau of Labor Statistics nor the Small Business Administration have current statistics of average wages by firm size, making it very difficult to know how many firms will be eligible for the subsidies. The CBO study found the employer subsidy program is underfunded by $72 billion in the first five years of the program. Then there is history. In 1965, Medicare was estimated to cost $9 billion by 1990. It actually cost $116 billion. Attempts to project entitlement costs, virtually all analysts agree, are very difficult and almost always off. When cost estimates of the subsidy prove to be low, the payroll caps will once again be undermined.

As Energy and Commerce Health Subcommittee Chairman Henry Waxman said last October, "[The subsidy caps) could mean the money just won't be there for low income people and small businesses."

(3) The wage criteria for the payroll caps are not indexed for inflation, meaning that as wages go up in a firm even if only for cost of living adjustments, so will health insurance costs.

(4) The Health Security Act allows the states and the National Health Board or Congress to adjust the already generous standard benefits package. Recent experience has clearly shown that a federal government fiscally restrained by huge deficits is inclined to pass ad take credit for benefits for which it does not have to pay. If this should happen with the standard benefits package, the small business subsidy would cover less and the employer mandate would cost more.

In light of all the data on the high cost to small business of the employer mandate and the low reliability of the small business subsidy, it is clear that the employer mandate in the Clinton plan or variations of it represent the wrong way to finance health care reform. While this view embodies the growing consensus, there are still numerous compromises being discussed regarding the mandate. This brings us to the third and final question:

3. How would other forms of health insurance employer mandates affect small businesses and the people employed by them?

As employer mandate detractors have raised small business concerns that have taken hold, supporters of the mandate have struggled to save it through compromise. While these diluting compromise plans are a sign that mandate proponents are moving in the right direction on this question, NFIB believes that such mandate variations should be rejected. Health care reform should happen this year, but it should happen without any form of employer mandate.

Three major employer mandate variations have emerged in recent weeks: (1) an employer mandate for firms with more than 100 employees and an individual mandate for smaller firms, (2) a trigger mechanism whereby an employer mandate would be implemented at some designated point in the future if universal coverage is not achieved by that date, and (3) a 50% employer mandate, instead of an 80%

employer requirement Details of these proposals are currently developing, but it is clear that all three have numerous problems associated with them.

The first two, the so called small business exemption and the trigger mechanism, should be considered simultaneously because they have two problems in common from the point of view of the small business community. They both stem from the fact that these proposals, through various means, would place into law the idea that employers are responsible for the health insurance of employees as a condition of being an employer. In the case of the small business exemption, the legal obligation exists for the employer who creates more than 100 jobs. In the case of the trigger mechanism, all employers are held responsible if reforms do not achieve universal coverage. The concerns raised by such a legal obligation are financial, practical, and philosophical.

Such an obligation, whether imposed on larger employers or used as a backup for universal coverage, immediately brings to mind an observation made by the Chairman of this Committee. In September of last year, Chairman Moynihan said the following regarding the financing of government entitlement programs: "In the past, we [the federal government] have all been wrong." Surely that view of history is correct, and it is the basis of the first concern regarding the exemption and trigger mechanisms There can be no disputing it. As a result, small business owners understand that any employer mandate to finance an entitlement will be a floor of that employer's expense, not a ceiling. Just look at other employer obligations that have financed entitlements:

(1) 1965 cost estimates of Medicaid expenditures were off by 7600%.
(2) 1965 cost estimates of Medicare expenditures were off by 1178%.
(3) Social Security was originally financed by a 1% payroll tax. Today, a self employed person pays 15%.

While previous employer financing efforts have been for entitlements that serve only a segment of the population, a health insurance entitlement to a standard set of benefits would cover all Americans, making financing forecasts even more tenuous. The result is that any additional assurances by the federal government to employers that their exposure from an entitlement would be strictly limited are dubious at best. The result is the small business exemption would shrink, or the trigger mechanism would surely be implemented. The result is that small employers, once it is established that employers at some level are responsible for coverage, would be tied to a cost of a benefit over which they would have no control. They would be asked to do more when the government only has the money to do less.

The second concern that arises regarding the exemption and the trigger is that they are philosophically contradictory to the view of the small business community on how health care are reform should be achieved. NFIB polling shows that most small business owners believe that, as stated earlier, providing health insurance for employees is a competitive advantage. They believe that cost is the primary barrier to employers who do not provide insurance. They believe there is insufficient competition in the health insurance marketplace. They believe that every America has a right to basic health care, and that health insurance should be one of the first employee benefits that employers provide. But they reject the notion that small business owners, who take risks, often borrow money to start a business, and create the vast majority of new jobs in this country, should be *required* to provide health insurance. 87% of NFIB members believe that ultimately health insurance is an individual responsibility. These compromise mandates do not reflect this view. Other proposals in Congress that espouse the goal of universal coverage do.

The 50% employer mandate shares the drawbacks mentioned regarding the other compromise mandates, and then some. It has all the same problems as the Health Security Act mandate. It is a payroll tax, which is regressive and hits labor intensive small businesses the hardest. It would also hit minority and women-owned firms very hard. It would result in job loss for the same reasons discussed earlier. It is still a cost increase to the vast majority of small firms because the vast majority currently cannot afford or gain access to health insurance for their workers. And it is also a cost increase for some firms that currently provide insurance but do not offer as rich a package of benefits, have higher employee deductibles and copayments, or do not provide benefits for part-time and seasonal workers. Like other mandate proposals, it reduces an employer's role in providing health benefits to simply writing a check for a cost he or she cannot control.

Some will argue that the employer mandate is indispensable; that health care reform cannot happen without it. This view is simply not correct. This committee, all of Congress, and the President have an enormous opportunity to remove all barriers to purchasing health insurance and expand health care coverage to those who cannot afford it without an employer mandate. NFIB supports numerous steps that

would take us in this direction: voluntary small business purchasing groups, insurance reforms, malpractice reforms, administrative reforms, 100% deductibility of health premiums for the self employed, preempting costly state mandates, and providing for a basic package of standard benefits. These steps would bring health care costs down and make it easier for small business owners to purchase health insurance for their employees. These steps embody the emerging consensus, as I have indicated, on how to reform America's health care system.

As for bringing the 38 million uninsured Americans into the system, there are other proposals besides the employer mandate in the debate that would subsidize uninsured individuals directly. NFIB has worked with members of this committee on both sides of the aisle, such as Senators John Breaux and John Chafee, on alternative proposals they support which would do just that. There are a variety of ways this kind of health care reform could be financed: tying employer deductibility of health benefits to the cost of the standard benefits package, limiting the tax free transfer of health benefits to employees, an individual mandate, and reductions in the rate of growth in Medicare and Medicaid are among them. I am not here to endorse any single one of these, but to say that they are worthy of your consideration as an alternative to a financing mechanism that would be very damaging to Main Street small businesses, their employees, and the overall national economy: the employer mandate.

NFIB supports numerous health care reform plans offered by members of both political parties that do not include the employer mandate. I am hopeful we can work together to find a solution that does not achieve health security at the expense of job security.

Thank you.

PREPARED STATEMENT OF BERNARD F. BRENNAN

Chairman Moynihan, Mr. Packwood, and distinguished Members of this Committee, my name is Bernard F. Brennan. I am Chairman of the National Retail Federation (NRF) and Chairman and CEO of Montgomery Ward & Co. I appreciate the opportunity to testify today on behalf of the NRF and to present the views of the retail industry and Montgomery Ward on key health care issues of concern to retailers.

As a company with 60,000 employees, Montgomery Ward offers a comprehensive plan to all full-time employees and part-time employees working over 30 hours a week. Montgomery Ward established a milestone in 1912 when it became the first American company to offer health care coverage to its employees. Montgomery Ward and the retail industry share the Administration's vision of quality, affordable health care for all Americans. Retailers need and want health care reform to control increasing health insurance costs and guarantee access to coverage for all Americans.

We endorse significant and meaningful reform measures that would control health care costs and reduce insurance premium increases without negatively impacting the retail job market. Specifically, we support:

- effective, market-based solutions to control health care costs, without global budgets or price controls;
- efforts to encourage the formation of voluntary health insurance purchasing groups to make health insurance more affordable for individuals and small businesses;
- insurance reforms which limit preexisting condition exclusions and guarantee availability, renewal, and portability of coverage;
- medical malpractice reforms which reduce defensive medicine practices and emphasize alternative dispute resolution.

However, the National Retail Federation firmly believes that **health care reform must not be achieved at the cost of our nation's economic health.** Therefore, we strongly oppose any health care plan which mandates employers to purchase health insurance coverage for their employees. Implementation of an employer mandate would cause a massive disruption to the retail industry and our nation's overall economy. Studies have estimated that **up to 3.1 million jobs** would be lost under an employer mandate, with over 75 percent of the lost jobs coming from labor-intensive, low-wage industries such as retailing.[1] **These are the very people who can**

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[1] O'Neill, June E. et al. *The Impact of a Health Insurance Mandate on Labor Costs and Employment.* Washington, D.C.: Employment Policies Institute, Sept, 1993.

least afford a decrease in income for wage reductions or loss of their jobs in return for health care coverage.

The National Retail Federation believes that health care reform can, and must, be achieved without major damage to our nation's economy. We want to work with Congress to ensure that the cure to what ails our nation's health care system is not worse than the disease.

WHY THE RETAIL INDUSTRY IS UNIQUELY SITUATED IN THE DEBATE ON HEALTH CARE REFORM

We believe that a successful health care reform plan must take into account the unique size, function and economics of retailing. Retailers employ 20 million people—**one in five U.S. workers.** Fully 25 percent of the recently unemployed obtain new jobs in retailing. Retailing contributes greatly to our nation's economic vitality. Between 1979 and 1992, the retail industry has created **3.4 million jobs,**[2] while some other sectors of the economy have actually lost jobs. In addition, retail job creation causes an economic ripple effect through other industries. Every 10 retail jobs **create 4.8 jobs outside of retailing**—in manufacturing, transportation, and other sectors.[3]

The job of retailing is to serve its customers. Many retailers—like my company—are open seven days a week, 11 to 12 hours a day (some even 24 hours a day) to accommodate the needs of today's customers. In addition, peak buying periods define much of the business. For example, a recent Arthur Andersen study shows that hourly sales velocity and customer traffic volume can vary by a multiple of thirty-five during different one-hour periods in one day. In contrast to continuous production processes which require stable work schedules and accommodate full-time work shifts, these unique retailing factors make it necessary for us to maintain a very flexible workforce which includes large numbers of part-time and seasonal workers.

A recent study by an independent economic consulting firm[4] confirmed that 73 percent of part-time employees specifically choose part-time employment because it fits their needs. Companies like Montgomery Ward and other large and small retailers provide the jobs which make ends meet for **millions of part-timers** who are **working mothers** and **single parents** and need flexible schedules, **older workers** who want to keep active, **teenagers** getting a first taste of the working world and **college students** working to contribute toward their educational expenses.

Retailing is highly labor-intensive and competitive. Its profit margins are very thin, and can be as low as 1 to 3 cents on the dollar. Since 1990, over 50,000 retailers have filed for bankruptcy. Forty-three of the top 100 department stores operating in 1980 are no longer in business.

ANY FORM OF AN EMPLOYER MANDATE DISPROPORTIONATELY IMPACTS THE RETAIL INDUSTRY

Because a mandate requiring employers to pay their employees' health insurance premiums translates directly into increased labor costs, its impact will be felt most strongly in labor-intensive industries with high concentrations of lower-wage workers such as the retail industry. The continued ability of Montgomery Ward and other U.S. retailers to create jobs and to contribute to national economic prosperity would be threatened by the massive new costs that such a mandate would impose on employers.

Productivity data underscores why an employer mandate would have disastrous consequences for the retail industry. On an annual basis, a full-time equivalent retail employee produces $1740 in corporate earnings while a full-time manufacturing employee produces $6447 in corporate earnings. Thus, on average, it takes over 3.7 retail employees to equal the productivity of a single manufacturing employee. According to the Employment Policies Institute, **the retail sector ranks lowest in per-worker contribution to company earnings.**

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[2] Source: Bur. of Economic Analysis, U.S. Dept of Commerce.

[3] Source: Bur. of Economic analysis, U.S. Dept of Commerce; Dep't of Economics, University of Illinois at Chicago.

[4] Source: The Trade Partnership, Washington DC.

PRODUCTIVITY AND HEALTH CARE COSTS IN RETAILING COMPARED WITH MANUFACTURING

	Annual corporate earnings per FTE [5]	Employer cost of individual health care [6]	Cost of individual coverage as % of earnings [7]	Employer cost of family health care [8]	Cost of family coverage as % of earnings [9]
Retailing	**$1,740**	**$1,656**	**95.2%**	**$3,864**	**222.1%**
Manufacturing	**$6,447**	**$1,656**	**25.7%**	**$3,864**	**59.9%**

[5] Source: "Survey of Current Business," Aug. 1993, Bur. of Economic Analysis, U.S. Dep't of Commerce. $6,447 company earnings per full-time equivalent manufacturing employee/$1,740 company earnings per full-time equivalent retail employee = 3.7:1.

[6] Employers mandated to pay 80% of the cost of individual coverage of the $2070 per year (15% above the Administration's estimate per estimate by the CBO), or $1656.

[7] $1656 employer cost/$1740 company earnings per full-time equivalent = 95.2%. $1656 employer cost/$6447 company earnings per full-time equivalent = 25.7%

[8] Family coverage would cost 80% of $4830 per year (Per CBO), or $3864.

[9] Retail: $3864 employer cost/$1740 company earnings per full-time equivalent = 222.1%. Manufacturing: $3864 employer cost/$6447 company earnings per full-time equivalent = 59.9%.

As detailed in the chart above, a mandate requiring employers to pay 80 percent of their employees' health insurance premiums would cost retailers $1,656 per year for single coverage. This is 95.2% of what a full-time retail employee produces in earnings. Eighty percent of family coverage, would cost $3,864 or 222.1% of what a full-time retail employee produces in earnings. The cost-earnings difference for part-time workers would be even greater. **Clearly, the productivity of these low-wage retail employees cannot justify health care coverage that massively increases their total compensation costs.**

In addition, of all the major industries, the retail sector would experience the greatest percentage increase in the number of workers who would become insured by their own employer under an employer mandate.[10] Thus, the price tag for health care reform under any mandate would be disproportionately borne by retail employers. Moreover, a mandate would impose additional substantial administrative costs for labor intensive industries. Such cost would be dramatically magnified were the ERISA preemption weakened and waivers given to individual states.

A recent Lewin-VHI analysis of the Health Security Act reveals that, compared to other industries, the retail industry would experience by far the sharpest increases in health spending under an employer mandate.[11] The table below illustrates the disparate impact a mandate would have on the industry.

NET CHANGE IN HEALTH SPENDING FOR PRIVATE FIRMS IN SPECIFIC INDUSTRIES IN 1998 UNDER HEALTH SECURITY ACT [12]

Industry	Net Change	Average Per-Worker Increase
Construction	$1.6 billion	$243.00
Manufacturing	($2.1 billion)	($96.00)
Trans., Comm., Ut.	($4.3 billion)	($628.00)
Wholesale Trade	($0.7 billion)	($177.00)
RetailTrade	$17.1 billion	$1,167.00
Services	$15.0 billion	$576.00
Finance	$0.8 billion	$127.00
Other	$1.5 billion	$334.00
Total Private	$28.9 billion	$319.00

[12] Source. Lewin-VHI estimates using the Health Benefits Simulation Model.

Lewin-VHI estimates that, by 1998, retail employers' health care costs would increase by an average of **$1167 per worker.** When you compare this type of increased cost with the company earnings per full-time retail equivalent employee ($1740), you begin to see the true imbalance of the additional cost burden on the retail and other labor-intensive, low-wage industries. In comparison, the service and construction industries would experience an average per-worker increase of $576 and $243 respectively. **Of the projected $28.9 billion increase in health spending among private firms in 1998, the retail industry would bear 59% or $17.1 billion.**[13] Obviously, the retail industry cannot absorb such a massive cost increase.

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[10] Sheila Zedlewski, "Expanding the Employer-Provided Health Insurance System: Effects on Workers and Their Employers," *Health Benefits and the Workforce*, 1992.

[11] Source: Lewin-VHI, Inc., *The Financial Impact of the Health Security Act* (Dec. 9, 1993).

[13] Id at 76.

JOB LOSSES UNDER AN EMPLOYER MANDATE

Because many retail employees are at or near minimum wage, their cash compensation cannot be altered. Thus, retailers cannot, as can higher-wage employers, shift the increased costs resulting from an employer mandate back on to wages. Nor can retailers simply pass these cost increases onto customers through price increases. Many retail purchases are discretionary in nature and deferrable. Also, due to intense competition, major segments of the retail industry are experiencing price deflation in many merchandise categories. During the 1980's, retail square footage grew by over 50% while the population increased by only 10%. This resulted in extensive pricing pressure on all retailers causing price decreases in many products. Bureau of Labor Statistics data disclose that the 75 billion dollar consumer electronic industry has experienced significant deflation since 1989. This is true at Montgomery Ward as well since our products are priced very competitively in the market. As an example, industry figures show that the average price of a camcorder in 1989 was $1014 compared to $777 in 1993. The average price for VCR's in 1989 was $329 which has decreased to $239 in 1993. It is obvious that in the current low-margin retail industry, we simply cannot pass higher prices on to consumers.

Since we are unable to recoup costs through price increases, cannot shift increases in labor costs to low-wage employees and cannot operate at a loss and remain a viable business, we are left with but one choice under a health care employer mandate: to reduce labor costs through a reduction of jobs and wages. Basic economics require that an essential relationship must exist between the compensation provided an employee (wages and benefits) and the economic value received by the employer.

As the author of one study on employer mandates notes, **"[w]hen industries cannot shift [increased labor costs] the inevitable result is the loss of jobs, with the job loss increasing with the unshiftable cost."[14] This statement is consistent with mainstream economic thought.**

For example:

- Leading Democratic economist Lester C. Thurow of MIT's Sloan School of Management stated that **"The Europeans have taught us that mandated benefits end up pricing labor out."[15]**
- A survey of leading American economists conducted by the University of New Hampshire revealed that **80 percent believe that imposition of an employer mandate will result in the loss of lower-wage jobs.**
- The Joint Committee on Taxation, in its analysis of the Health Security Act's employer mandate, noted that "[e]conomists generally believe that **payroll taxes are borne by employees."**
- Robert Shapiro, Vice President of the Progressive Policy Institute, wrote in the New Democrat that **"[f]ar from guaranteeing benefits to low-skilled workers, a rigid employer mandate, by the economics of it, would probably cost many of them their jobs."**
- A USA Today/CNBC survey of 55 economists revealed that 78 percent fear that enactment of the Administration plan would **slow employment growth.[16]**
- Business Week's Bill Javetski, who covers European economic policy, notes the Administration's contention that there's a lot we can learn from the Germans whose national health program provides comprehensive coverage at a mere 9% of gross domestic product, compared with 14% in the U.S. Javetski points out: "But what the President isn't factoring in is the cost employers pay, on top of wages, to support the systems. **In fact, across the European community, benefits costs—mostly for health insurance—are twice those in the U.S. The EC now admits that such costs are a big reason why the U.S. created 20 million jobs in the 1980s while Europe produced barely any."**

Numerous studies document the job loss which is almost certain to occur as a direct result of an employer mandate:

- A study conducted by Nathan Associates, Inc. for the National Retail Federation conservatively estimated that **at least 500,000 retail jobs** would be eliminated under an employer mandate. **A modest 5% reduction in the 20 million worker retail industry would be 1,000,000 jobs.**
- The Employment Policies Institute estimates that **retail job losses could total 726,000** under a mandate.
- A CONSAD study analyzing the potential employment impact of several major health care reform proposals concluded that "estimates of job losses **exceeding**

[14] O'Neill et al.
[15] *Business Week*, January 24, 1994.
[16] USA Today/CNBC survey of 55 economists, 10/1/93.

1,000,000 from the more rigorous employer mandated proposals are not unrealistic."[17]

- One study found that imposition of an employer mandate could result in the **loss of 3.1 million jobs nationwide with over 75 percent of the lost jobs coming from labor intensive, low-wage industries such as retail, restaurant and agriculture.**[18]

These job loss concerns are consistent with an extensive analysis by Montgomery Ward undertaken in conjunction with nationally recognized benefit consulting firms. An employer mandate affords management virtually no choice. We truly want to grow jobs and the business. However, to continue to run a viable business in the face of an employer mandate, we would be forced to find ways to offset cost increases due to the mandate. We would have to closely analyze our retail and support operations to determine where such costs might be reduced. In the labor-intensive retail industry, where labor is our number one cost, we would have to scale back our workforce.

Most retailers would have no choice but to cut jobs or reduce work hours in order to meet the increased costs they would face under an employer mandate. This is a very painful process which I had to undertake once before. When I joined Montgomery Ward in the mid 1980's, I encountered an excessive cost structure which caused the company to face potential liquidation. Had we not eliminated 17,000 jobs in order to save 60,000 other jobs, Montgomery Ward would not be in business today.

Low-wage employees, who have less opportunity to trade wages for health benefits, are the most likely to suffer the effects of these costs. **That is the truly tragic irony of an employer mandate; the very people government is trying to help would, because of this terribly misguided but well-intentioned approach, suffer the loss of something far more valuable to them and their families—namely, their livelihood.**

THE DIRECTION OF HEALTH REFORM AND SUBSIDIES

Private citizens and businesses, both small and large, are acutely mindful that governmental programs are, upon enactment, often merely a starting point. Our experience leads us to believe that it is the direction of the program that is crucial, not necessarily its components, minimal size, or in the present case, subsidy features. In the case of health care employer mandates, business owners, small and large, frequently remind me that starting down the wrong road, even with a timid step, can quickly turn into a fiscal quagmire. An employer mandate is simply an entitlement program funded by business. I don't need to explain to this Committee our nation's track record in controlling the costs of entitlement programs. As reported by the Washington Post, in 1965, it was estimated that by 1991 the Medicare program would cost **$9 billion per year.** The actual cost of the program in 1991 was over **$100 billion per year.** Another example of a well intended program that dramatically exceeded government cost estimates is the federal Medicaid Hospital Subsidy Program which made mandatory disproportionate share payments to hospitals handling large numbers of poor patients. In 1987 the Congressional Budget Office estimated that it would cost the federal government only $95 million over the next three years to cover its share or an average of **$32 million per year.** In 1992, just five years later, the program cost the federal government **$10.8 billion. Governmental programs once begun are often irreversible as to direction and growth. For these reasons, we firmly believe that the direction taken in the reform of health care is of paramount importance.**

As we embark upon the journey to reform health care, we need to clearly focus in a thoughtful and logical manner upon the specific problems in our health care system and address them directly. Altering insurance regulation can eliminate barriers to health insurance for people with pre-existing conditions. Insurance reforms could guarantee uninterrupted coverage to employees upon leaving their employer. The elimination of existing regulatory barriers would permit small business insurance pools to purchase insurance collectively, increasing their bargaining power and significantly reducing their costs. Medical malpractice reform would also reduce health cost, as would the standardization of claim and other forms. For low-income workers unable to qualify for Medicaid but unable to afford an insurance plan, a government voucher or tax credit system could help ensure adequate coverage. The NRF supports efforts to subsidize the health insurance costs of low-wage employees.

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[17] The Employment Impact of Proposed Health Care Reform on Small Business. Washington, D.C.: CONSAD Research Corporation 51. 1993.

[18] O'Neill et al.

We urge your consideration of a bipartisan, uniform plan which incorporates the principles of market based reform at the federal level.

In addition to the devastating economic consequences described earlier, the major objective of cost control is incompatible with the proposed employer mandate. Employer involvement in the control of costs is essential. We must have the flexibility to work with our employees in the careful expenditure of health care dollars. An employer mandate effectively removes the incentive to do so. **Failure to recognize this would be, I fear, a tragic and irreversible mistake at this pivotal time.**

WHEN IS THE CURE WORSE THAN THE DISEASE?

Our nation's health care system is truly massive and complex. The economic and social implications of health care reform exceed those of virtually any other issue. Your decisions will dramatically affect not only the $900 billion per year health care industry, but the $2 trillion per year retail industry, other labor intensive industries and every remaining segment of business. Of equal, if not greater, importance is the unique value placed by Americans on the nature and quality of the health care they receive.

We urge you not to ignore the dire warnings of business people throughout retailing and other labor-intensive industries as well as leading economists as to disastrous effects of an employer mandate on jobs and our economy. Such a mandate, if enacted, would:

- **Tragically cause many of those individuals most in need of health care coverage to lose something they and their families need and cherish far more—their means of earning a livelihood.** Numerous economic authorities, including leading Democratic economist, Dr. Lester C. Thurow of M.I.T., have analyzed the impact of an employer mandate on the U.S. economy in light of experience in the European community and elsewhere and concluded that such a mandate would seriously damage jobs and the economy.
- **Effectively remove from businesses the capability to control health care costs.** An employer mandate would stifle creative approaches and the careful expenditure of health care dollars by individuals and business. With little ability to reduce costs (a mandate effectively fixes costs), business will have virtually no incentive to explore methods of doing so.
- **Devastate labor-intensive industries and the economy**—the retail industry which employs 20 million workers (one in five) would, under the Administration's proposed employer mandate, be faced with a cost increase in health care spending of $17.1 billion of the projected $28.9 billion increase in health care spending in 1998 among business. Employers would have no choice but to dramatically reduce labor costs, i.e. jobs, to stay in business.
- As an employer who views with pride our historical legacy as the first American company to offer health care coverage to our employees in 1912, and as a concerned industry, we want to continue to meet the needs of our workers and the consumers we serve. We look forward to working with Congress to achieve the goal of quality health coverage for all Americans while addressing the critical issues raised today.

PREPARED STATEMENT OF STUART M. BUTLER

My name is Stuart Butler. I am Vice President for Domestic and Economic Policy Studies at The Heritage Foundation. My testimony represents my personal views on the issue of health care reform, and should not be construed as representing any official position of The Heritage Foundation.

I wish to thank the Committee for the opportunity to testify on the important topic of how to secure adequate health insurance coverage for all Americans. In my testimony I will address three issues:

(1) Why the design of the current system leads inexorably to the absence of universal coverage and high levels of involuntary uninsurance.

(2) The severe shortcomings of an employer mandate as a device to secure universal coverage. In doing so I will present the main findings of a new study of the Clinton plan (the Health Security Act) conducted for Heritage by Lewin-VHI. This analysis shows that including the effect on wages of an employer mandate substantially reduces the attractiveness of the Health Security Act in terms of "winners" and "losers" among working-age households.

(3) How universal coverage can be achieved in a system built on individual ownership of insurance and non-employment groups as sponsors. This system is the basis of legislation introduced by Senator Don Nickles (S. 1743, The Consumer Choice

Health Security Act). The same Lewin-VHI analysis indicates that under the tax credit approach of the Nickles bill, families in every income bracket are significantly better off than under the Clinton Administration's employer mandate.

WHY THERE IS INADEQUATE COVERAGE TODAY

The primary reason we have the serious problem of millions of working Americans wanting insurance but unable to obtain it—or losing the coverage they now have—is because most health insurance is employer-based. Michael Graetz, another panelist, has explained that this system is an historical accident. It continues because families face a huge tax penalty for obtaining coverage through any other mechanism, such as buying it directly or obtaining coverage through some alternative group, such as a union. This tax penalty, and the lack of any significant federal assistance other than this form of tax relief, explains part of the uninsurance problem.

The second, related reason is that under the employer-based system, the employer actually owns the plan and decides the benefits (either arbitrarily or by a bargaining with the union). The employer also controls the amount of a worker's total compensation that will be devoted to coverage. Thus unlike life insurance or homeowner's insurance, a health insurance typically does not belong to the person insured. Hence a change of job, or any employer-decided change in benefits, can mean the loss of insurance, or at the very least a change in coverage.

Until this system is changed, there will always be a problem in America of families unable to acquire the plan that is best for them, and always a fear that coverage will be interrupted or lost. Until it is changed, it will be impossible to achieve universal coverage, or anything approaching that goal.

THE HEAVY COST OF AN EMPLOYER MANDATE

Some Members of Congress, as well as officials of the Clinton Administration, maintain that the way to resolve the problems I have outlined is to require all employers to provide comprehensive coverage, adding subsidies to certain employers and workers. But an "employer mandate" is in practice merely a disguised individual mandate—and so Congress should focus on that latter device. Moreover, as a new analysis of the Health Security Act shows, the "pass-through" of an employer-mandate in the form of reduced wages would be heavy and very regressive.

An employer mandate is in a real sense meaningless because all it means in practice is that employers are required to earmark a specific portion of a worker's total compensation for the purchase of health insurance. The lion's share of this money in other words, comes out of the worker's paycheck, not the employer's profits. In a review of the economic literature, Lewin-VHI notes that approximately 88 percent of the cost of any such mandate would be passed on in reduced wages.

According to a new Lewin-VHI analysis of the Health Security Act, which is provided to members of the committee, the employer-mandate in the Act would in 1998 mean reducing the wages of workers in firms not currently providing insurance by an average of about $1,243, or 6.1 percent. This wage cost, I should note, is in addition to the change in family health costs associated with the plan, the details of which were identified by Lewin-VHI in their December 9, 1993 analysis of the Health Security Act. In addition, Lewin-VHI points out that in the case of many lower-income employees, a loss of job is more likely in practice than a reduction in wages. Lewin-VHI estimates the range of job losses at 155,000–349,000, heavily concentrated among lower-paid workers.

THE ONLY OPTION FOR UNIVERSAL COVERAGE: AN INDIVIDUAL-BASED SYSTEM

If universal coverage is to be achieved, the only possible method to meet that goal would be to require individuals to obtain coverage and to provide lower-income households with the means necessary to comply with that requirement. An employer mandate is merely a hidden and incomplete mandate on individuals. The Clinton Administration evidently recognizes this, since the Health Security Act actually places the ultimate obligation on individuals to choose a plan and to pay their share of the premium.

There can and should be much discussion of what universal coverage actually means and whether it is even desirable. Does it mean an assurance that anyone who wants insurance protection can obtain it at an affordable cost (including any subsidy they may receive)? Does it mean people should be required to have a certain level of insurance whether they want it or not? Does it mean protection against catastrophic costs or insurance "protection" against the cost of a $20 prescription?

For the sake of discussion, I will explore the idea that the goal is two-fold. First, to assure that all Americans not in government health programs can in some way obtain an adequate level of health care, including protection against catastrophic

health care costs, at a reasonable cost to the household. And second, that all such Americans must carry at least catastrophic insurance. This second element would be to protect society from the potential cost of an individual who otherwise might refuse to buy insurance and yet incurred high medical bills in, say, an emergency room. In other words, it would be liability insurance for the rest of society which is paid for by each individual.

If this is the objective, with every American protected against at least catastrophic health care costs, the ideal reform would have to contain certain key elements. After discussing these, I will note how the Consumer Choice legislation (S. 1743) offered by Senator Nickles substantially achieves these and then I will summarize Lewin-VHI's analysis comparing the financial impact of S. 1743 and the Health Security Act.

Element 1: Families must be free to choose any plan (and set of benefits) irrespective of their place of employment, and with the same tax relief wherever they obtain their plan or care.

The current tax code heavily penalizes households who do not obtain their care through an employer-owned plan. To open up more sensible avenues for families the tax code would have to be neutral with respect to where a family obtained its plan. Thus the tax code would have to treat the family the same, whether the plan was sponsored by an employer (as today), a union, a church, some other sponsoring group, or directly form an insurer. Ideally, the tax code also should not discriminate between paying for health care through insurance, out-of-pocket, or by disbursements from a special account (sometimes called a "medical savings account"). This latter tax neutrality would enable families, without any tax distortion, to decide the most economical balance of insurance and direct health spending.

To enable families to make a rational choice between obtaining coverage through an employer-based group or some other group, employees with company-sponsored plans would have to have the right to "cash out" the actuarial-value of their current benefits and put this money towards an alternative plan.

Element 2: All working-age households not in Medicaid would have to obtain at least a catastrophic plan.

If the objective of Congress is protection against catastrophic medical costs for every American, then obtaining such coverage would have to be a legal requirement. Otherwise the goal cannot possibly be achieved because some individuals will refuse to insure themselves and yet could receive substantial services under the current legal obligations faced by hospitals. But two caveats are important here. First, such a requirement is not a requisite for an individual-based system as such, but only if Congress' objective is universality. And second, if the goal is to achieve a situation close to universality (recognizing the difficulty of 100 percent coverage), then a mandate may be unnecessary.

Element 3: The current structure of tax relief would have to be changed, and/or revenue changes made to assist low-income families.

The current tax exclusion provides generous tax relief to upper-income households, in high tax brackets, and very little to lower-income families. If lower-income families are to be able to afford at least a basic plan, the method of tax relief would have to change, to provide more assistance to low-income families. The ideal form of tax relief, bearing in mind budget considerations, would be to replace the current tax exclusion with a refundable tax credit. To maintain budget neutrality, any net shortfall in revenue would have to be offset with other program reductions.

Element 4: There would have to be changes in insurance regulations.

If households are to choose and own their own plans, and to be secure in the knowledge that they have insurance that cannot be discontinued, there would have to be certain changes in insurance law. For one, states would have to be prohibited from mandating certain insurance benefits beyond any minimum required by federal law. For another, insurance companies would have to renew coverage each year, at the choice of the policyholder. And, I would argue, insurance companies need to be limited in the risk factors they can consider when quoting premiums. We propose limiting underwriting to age, sex and geography.

If this change is not made, problems arise in the case of high-risk households who would otherwise not be able to afford catastrophic protection, even with tax changes and government subsidies. The alternative would be some form of government-sponsored and subsidized risk pool for these households. But that means a large new federal program (potentially a "Medicare, part C"), and with it the threat of another source of out-of-control federal health care spending and counterproductive price controls.

HOW THE CONSUMER CHOICE BILL ADDRESSES THESE ELEMENTS

In essence, S. 1743 would change the current health system such that families could choose the health plan and benefits that suited them best. They could obtain a plan directly from an insurer, or through a large group (such as a union, church or farm bureau), and so obtain the advantages of a large buyer. Families would own their plan, and it would move with them from job to job. And through changes in the tax code, families would be assured of at least basic coverage.

The main features that would achieve universal coverage, and would affect federal revenues are as follows. The budget figures are based on an analysis of how the Nickles Consumer Choice bill would affect household and government finances in 1998. The full study has been made available to the Committee.

- A refundable individual tax credit would replace the current exclusion available to households for company-sponsored health insurance. Under the bill, employer-paid health benefits would be subject to taxation, but these benefits, and other spending by the employee, would henceforth be eligible for the credit.
- The credits would be structured as follows:

Health Insurance Premiums and unreimbursed Medical Expenses as a Percentage of Gross Income	Tax Credit
Less than 10	25%
10–20	50%
Above 20%	75%

- A credit of 25 percent would be available for contributions to a medical savings account. In any year, contributions eligible for the credit in each household would be limited to $3,000 for the head of household and an additional $500 per dependent.
- Every individual or family would have to obtain a minimum package of health insurance to cover medically-necessary acute care. The maximum deductible would be $1,000 for an individual ($2,000 for a family) and an out-of-pocket limit of $5,000.
- Anyone not complying with this requirement would lose the personal exemption in the tax code. In addition, states would assign a plan to the individual in such cases and employers would deduct the appropriate premium payment.
- Employers would make a payroll deduction to cover premiums for the plan chosen by the employee. The employer would also adjust the employee's tax withholdings to reflect the -estimated credit available to the employee.
- If an employee currently with employer-sponsored insurance chose to obtain health insurance coverage from another source, employers would be required by law to "cash out" the actuarial value of the employee's existing benefits. The actuarial value would be based on age, sex and geography. In this case, employers would continue to make a payroll deduction and to adjust withholdings according to the cost of the new plan.
- The Medicaid Disproportionate Share program would be converted into a flexible grant program for the states to help low-income individuals not eligible for Medicaid to obtain health care. The purpose of the grants would be to keep total net out-of-pocket costs to no more than 5 percent of income for families with incomes below 150 percent of the poverty level.
- Insurers could not exclude coverage for preexisting conditions, nor could they cancel coverage (except for non-payment of premiums). Health insurance underwriting for individual or family plans would be limited to age, sex and geography. Discounts could be given to promote healthy behavior or early detection, and to reflect reduced marketing costs associated with group coverage.

Based on the "benchmark" analysis by Lewin-VHI for 1998, and CBO data, we estimate that these and the other provisions in the Nickles bill would lead to a small cumulative surplus in the federal budget over the next five years.

THE LEWIN-VHI ANALYSIS OF THE CLINTON AND NICKLES PLANS

The Heritage Foundation contracted with Lewin-VHI to carry out two analyses: (1) Lewin-VHI re-estimated the impact on families in 1998 of the Health Security Act, factoring in the effect of an employer mandate on wages. Lewin-VHI's December analysis of the plan confined itself to estimating the net effect on health spending. The new evaluation represents the true "bottom line" for families. Lewin also estimated job losses associated with the plan.

(2) Lewin-VHI carried out the equivalent analysis of the Nickles Consumer Choice Health Security Act. Hence, this estimated the net impact of the loss of the tax exclusion, the gain of the credit, changes in premiums and out-of-pocket health spending, and adjustments to wages of "cashing out" of company-provided plans.

Including the effects on household wages of an employer mandate substantially changes the "winners" and "losers" under the employer mandate approach of the Clinton legislation. What the Committee might find most remarkable is that the distributional "winners" and "losers" under the individual tax credit approach turns out to be far more attractive to households than under the Health Security Act, even for very low-income workers. Thus as a means of achieving universal coverage, the individual tax credit approach has significant advantages.

The Lewin-VHI findings are contained in the accompanying tables. To summarize the analysis and these tables:

- Assuming, based on the academic literature, that 88 percent of the cost of a mandate takes the form of reduced wages, the Health Security Act would involve an aggregate cut in wages in 1998 of about $20.6 billion. The average wage cut for workers not now covered by company-sponsored insurance would be $1,243.60. The largest number affected would be in the retail and service sector.
- Under the employer mandate in the Health Security Act, between 155,000 and 349,000 Americans would lose their jobs, chiefly among the lowest-income workers (see Tables 1 and 2).
- Prior to taking wage effects into account, Lewin-VHI estimated that the Health Security Act would reduce household spending on health care in 1998 by about $26.5 billion. But when wage effects of an employer mandate are included as a health cost for families, net health spending in 1998 falls by just $7.7 billion. By comparison, the Nickles Consumer Choice Health legislation would reduce total health spending in 1998 by $35.5 billion.
- The Lewin-VHI figures for spending under the Nickles bill do not include any assumption that consumer choice and competition will achieve a long-term downward trend in the growth of health care spending (even though the bill's sponsors claim that will happen). On the other hand, the Lewin-VHI analysis of spending under the Clinton bill assumes that the plans premium price controls and expenditure controls will be 100 percent effective (a point that is disputed by the Congressional Budget Office and most analysts).
- Tables 3 and 4 indicate the change in health spending under the Health Security Act when wage effects are not taken into account (Table 3) and when they are (Table 4). As the tables indicate, taking wage effects into account sharply changes the total net effect on average non-elderly households, especially in the case of the currently uninsured.
- When wage effects are included, the proportion of working-age households whose spending rises under the Clinton Health Security Act by at least $1,000 more than doubles, from 16.7 percent (ignoring wage effects) to 30.7 percent. The proportion of working-age households experiencing a net decrease of income (including wages and health costs) is 53.4 percent under the Health Security Act when wages are considered (Table 5), up from 49.5 percent if wage effects are ignored.
- When the Clinton Health Security Act is compared with the Nickles Consumer Choice Health Act, the Nickles bill produces a far better balance of "winners" and "losers." For example, under Nickles only 18.8 percent of working-age households see a total increase in costs of more than $1,000 after wage effects are considered (Table 6), compared with 30.7 percent under Clinton. And under Nickles, 39.4 percent of working-age families would experience a net reduction in costs of at least $1,000, but only 28.1 percent under Clinton.
- When the distribution of "winners" and "losers" is broken down by income group (See Tables 7 and 8), the Nickles tax credit approach leads to substantially more gainers in every income group—even among the working poor—than the Clinton employer mandate approach can accomplish.

CONCLUSION

This comparison of two approaches to achieve universal coverage, the employer mandate (The Clinton bill) and a more explicit obligation on individuals, combined with a tax credit (The Nickles bill), shows two crucial things. One is that an employer mandate has huge hidden costs, in wage reductions and jobs, that must be taken into account and will no doubt lead to public reaction if such a system is ever put into place. The second is that an individual credit approach can achieve the same stated coverage goal as the Clinton plan, and yet do so while reducing total

health costs for all income groups, cutting public programs less than the Clinton plan, and without depending (as the Clinton plan does) on price controls of questionable effectiveness or mandatory health expenditure cuts.

TABLE 1

ESTIMATED JOB LOSSES DUE TO THE HEALTH SECURITY ACT BY INDUSTRY (FULL AND PART TIME WORKERS) IN 1998

INDUSTRY	EMPLOYMENT	LOSSES	
		Elasticity = -0.2	Elasticity = -0.5
Construction	6,645,856	5,229	13,074
Manufacturing	21,875,590	28,022	41,767
Transportation	6,931,161	6,078	15,200
Wholesale Trade	4,121,199	1,023	2,536
Retail Trade	16,664,639	30,627	76,578
Service	29,735,649	47,914	110,511
Finance	6,937,199	4,057	10,135
Federal Government	3,443,223	5,150	12,875
State Government	5,121,197	9,081	22,704
Local Government	10,052,903	11,532	28,892
Other	4,619,694	5,857	14,639
TOTAL	116,148,310	154,571	348,915
Total less government	91,330,987	128,808	284,439

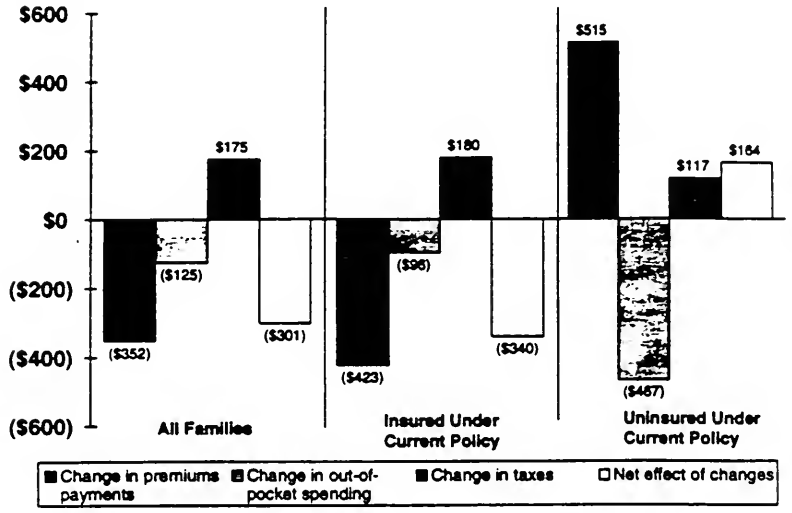
TABLE 2

ESTIMATED JOB LOSSES DUE TO THE HEALTH SECURITY ACT BY EARNINGS (FULL AND PART TIME WORKERS) IN 1998

EARNINGS	EMPLOYMENT	LOSSES	
		Elasticity = -0.2	Elasticity = -0.5
Less than $10,000	15,130,637	149,534	336,314
$10,000-29,999	40,149,316	5,037	12,601
Over $30,000	60,868,357	0	0
TOTAL	116,148,310	154,571	348,915

TABLE 3

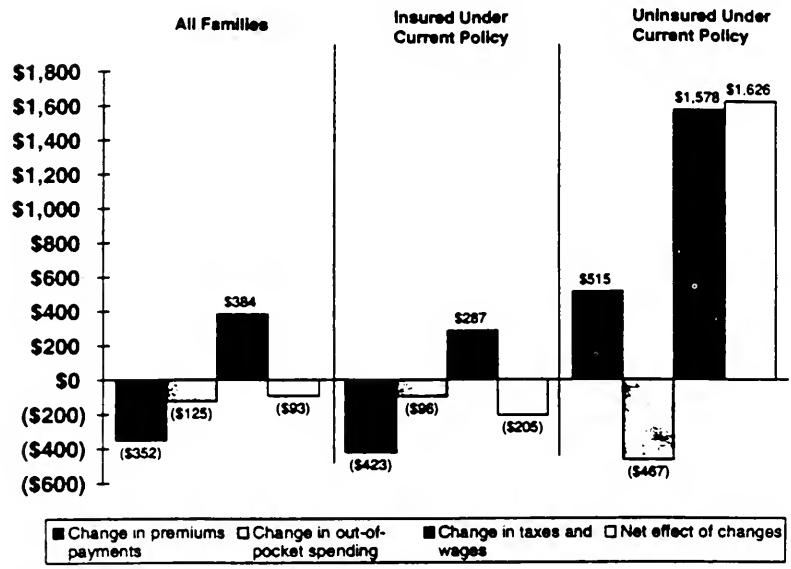
CHANGE IN HEALTH SPENDING FOR NON-AGED FAMILIES BY CURRENT INSURED STATUS WITHOUT WAGE EFFECTS (FAMILIES HEADED BY AN INDIVIDUAL UNDER AGE 65)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

TABLE 4

CHANGE IN HEALTH SPENDING FOR NON-AGED FAMILIES BY CURRENT INSURED STATUS WITH WAGE EFFECTS (FAMILIES HEADED BY AN INDIVIDUAL UNDER AGE 65)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

TABLE 5

DISTRIBUTION OF FAMILIES BY CHANGE IN HEALTH SPENDING NET OF CHANGES IN AFTER TAX INCOME UNDER THE HEALTH SECURITY ACT IN 1998[a,b]

Change in Health Spending Net of Changes in Income[c]	
Net Increase of $20 or More	**53.4%**
$1,000 or More Increase	30.7
$500 - $999 Increase	9.3
$250 - $499 Increase	6.9
$100 - $249 Increase	4.7
$20 - $ 99 Increase	2.3
No Net Change (less than $20)	**2.3%**
$20 - $ 99 Decrease	1.8
$100 - $249 Decrease	3.0
$250 - $499 Decrease	4.4
$500 - $999 Decrease	6.5
$1,000 or More Decrease	28.1
Net Decrease of $20 or More	**43.8%**
All Families	100.0%

a Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.
b Includes only families headed by persons under age 65.
c Includes the increase in wages under the program less the net change in household health spending including: changes in premiums and out-of-pocket spending; taxes on increased wages; and tax credits.

SOURCE: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

TABLE 6

DISTRIBUTION OF FAMILIES BY CHANGE IN HEALTH SPENDING NET OF CHANGES IN AFTER TAX INCOME UNDER THE INDIVIDUAL TAX CREDIT PROGRAM IN 1998[a,b]

Change in Health Spending Net of Changes in Income[c]	
Net Increase of $20 or More	**31.4%**
$1,000 or More Increase	18.8
$500 - $999 Increase	6.0
$250 - $499 Increase	3.4
$100 - $249 Increase	1.9
$20 - $ 99 Increase	1.3
No Net Change (less than $20)	**11.5%**
$20 - $ 99 Decrease	1.8
$100 - $249 Decrease	2.7
$250 - $499 Decrease	4.7
$500 - $999 Decrease	8.5
$1,000 or More Decrease	39.4
Net Decrease of $20 or More	**57.1%**
All Families	100.0%

a Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.
b Includes only families headed by persons under age 65.
c Includes the increase in wages under the program less the net change in household health spending including: changes in premiums and out-of-pocket spending; taxes on increased wages; and tax credits.

SOURCE: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

TABLE 7

DISTRIBUTION OF FAMILIES BY THE AMOUNT OF THE CHANGE IN TOTAL FAMILY HEALTH CARE EXPENSES FOR PREMIUMS AND OUT-OF-POCKET COSTS UNDER THE HEALTH SECURITY ACT (INCLUDES ONLY FAMILIES HEADED BY PERSONS UNDER AGE 65) IN 1998[a]

		PERCENT OF ALL FAMILIES										
		INCREASE IN FAMILY HEALTH COSTS						REDUCTION IN FAMILY HEALTH COSTS				
Family Income	All Families (In millions)	$1,000+	$500-$999	$250-$499	$100-$249	$20-$99	Change of less than $20	$20-$99	$100-$249	$250-$499	$500-$999	$1,000+
Less than $10,000	10,201.0	5.3%	8.0%	12.7%	11.9%	5.1%	9.3%	3.6%	5.4%	6.1%	5.9%	26.6%
$10,000-$14,999	6,920.9	34.8	13.3	6.4	5.9	1.2	2.5	1.8	1.8	3.2	4.7	24.4
$15,000-$19,999	6,208.0	36.8	9.5	6.2	3.8	1.0	2.2	1.9	3.6	4.8	5.6	24.4
$20,000-$29,999	12,195.7	32.2	11.9	8.4	4.0	3.1	1.9	1.1	2.7	4.3	6.7	23.7
$30,000-$39,999	10,032.8	32.1	8.4	7.6	3.8	1.5	1.0	1.7	2.4	4.7	6.5	30.8
$40,000-$49,999	9,505.6	28.9	8.0	6.2	3.8	2.5	0.8	2.0	2.8	5.7	6.5	33.4
$50,000-$74,999	15,158.3	35.0	9.2	4.4	3.5	1.9	0.7	1.8	2.9	3.8	7.1	30.0
$75,000-$99,999	6,475.4	38.0	7.2	3.7	2.7	1.5	0.7	0.9	2.7	4.2	7.3	31.2
More than $100,000	8,594.9	42.0	7.9	5.2	2.5	1.4	0.7	1.3	2.9	2.4	7.0	26.8
TOTAL	91,292.6	30.7%	8.9%	6.9%	4.7%	2.3%	2.2%	1.8%	3.0%	4.4%	6.5%	28.1%

[a] Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

SOURCE: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

TABLE 8

DISTRIBUTION OF FAMILIES BY THE AMOUNT OF THE CHANGE IN TOTAL FAMILY HEALTH CARE EXPENSES FOR PREMIUMS AND OUT-OF-POCKET COSTS UNDER THE INDIVIDUAL TAX CREDIT PROGRAM (INCLUDES ONLY FAMILIES HEADED BY PERSONS UNDER AGE 65) IN 1998[a]

		PERCENT OF ALL FAMILIES										
		INCREASE IN FAMILY HEALTH COSTS						REDUCTION IN FAMILY HEALTH COSTS				
Family Income	All Families (In millions)	$1,000+	$500-$999	$250-$499	$100-$249	$20-$99	Change of less than $20	$20-$99	$100-$249	$250-$499	$500-$999	$1,000+
Less than $10,000	10,201.0	1.6%	2.0%	0.7%	0.8%	0.6%	45.7%	4.0%	4.9%	5.6%	5.6%	28.3%
$10,000-$14,999	6,920.9	9.4	9.3	4.1	1.5	1.3	25.7	1.4	1.8	3.2	7.4	34.9
$15,000-$19,999	6,208.0	17.1	6.4	5.8	1.7	0.9	15.7	2.3	2.6	6.2	7.9	33.2
$20,000-$29,999	12,195.7	19.0	7.9	4.1	1.8	2.1	8.4	1.8	2.9	6.4	10.4	35.2
$30,000-$39,999	10,032.8	22.0	6.7	4.5	2.6	1.3	4.0	2.2	1.8	6.4	9.9	39.9
$40,000-$49,999	9,505.6	19.7	6.7	2.5	2.8	1.2	2.2	1.2	2.9	4.9	9.5	47.5
$50,000-$74,999	15,158.3	24.2	8.2	3.7	1.9	1.4	2.1	1.5	2.6	3.6	7.9	46.9
$75,000-$99,999	6,475.4	25.8	5.0	2.7	1.9	1.3	1.2	0.7	2.2	3.3	8.5	47.6
More than $100,000	8,594.9	26.8	9.0	2.9	2.4	1.1	1.7	0.7	2.0	4.2	9.5	43.1
TOTAL	91,292.6	18.8%	6.0%	3.4%	1.9%	1.3%	11.5%	1.8%	2.7%	4.7%	8.5%	39.4%

[a] Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuations in health services utilization.

SOURCE: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

PREPARED STATEMENT OF ALAIN C. ENTHOVEN

It is a privilege to appear before this important committee which is destined to play a crucial role in health care reform. And it is a pleasure to revisit some friends of long standing, especially the Chairman with whom I served in the Administration of President John F. Kennedy.

This Committee and this Congress find themselves faced with powerful conflicting forces that must be resolved if you are to legislate health care reform this year. Yet, reform is urgently needed. Health care expenditures are straining public finances at every level of government, and are pricing coverage out of reach for many families of moderate means. Any serious cost containment policy threatens morally unacceptable results if the poor are not well protected. Although there are some recent encouraging signs of moderation in expenditure growth, the market forces that are contributing to it must be sharpened and strengthened. While competition appears to be taking hold in California, it is not in many other parts of the country. Enlightened public policies could accelerate this process greatly.

President Clinton deserves great credit for elevating the problems of cost and access of health care to the top of the nation's policy agenda. This should have happened much earlier. But I believe the President has made the problems you face more painful and difficult by promising the impossible: cover the 39 million uninsured, add costly drug and long-term care benefits to Medicare, adopt a generous benefit package, limit employer contributions to 7.9% of payroll, and have government assume private employer early retiree obligations – all without a broadly based middle class tax increase and while reducing the deficit. I agree with the Chairman's characterization of this plan as "fantastic fantasy."

The President worsens the problem by calling a tax a non-tax and by making completely unrealistic forecasts of growth in health care spending. Neither the Canadian system nor the British National Health Service come close to meeting the cost containment goals required by the Clinton plan.

As the Congressional Budget Office all but said, the Clinton employer mandate is a tax. It certainly acts like a tax in many ways. Employer contributions inside the Alliances are originally capped at 7.9 percent of payroll – a number that is likely, over the years, to grow to 12 percent or more. And, as the government's hunger for "receipts" intensifies, it it is likely to become a frank payroll-tax on all earned income – just like the Medicare tax. The 7.9 percent cap also destroys the incentive of the employer to be actively involved in cost containment.

To expand coverage, taxes are necessary, and not necessarily all bad. However, I am concerned about the effect on incentives for some people like lab technicians, skilled production workers, and others in California who now face a combined federal and state (payroll and income) marginal tax rate of 50 percent, and who would be pushed into a rate over 60 percent, approaching rates we used to associate with Scandinavia. In Scandinavia, such rates created a culture of tax avoidance. We have recently seen a parade of high-level government appointees who did not pay a 15 percent payroll tax on household help. What can we expect at 27 percent?

As for unrealistic forecasts, the President's plan (and CBO) hypothesizes growth rates in real per capita spending at 1.5 percent in 1996, down to zero in 1999. This compares to 1985-1990 real growth rates of 4.6 percent in the US, 3.5 percent in Canada, and 2.5 percent in the UK.

I am optimistic that in the long run, given time for thorough system reform, for profound change in the culture of doctors and patients regarding resource use, time for many innovations in organization and management systems, practice patterns, personnel use, etc., and given the right incentives to motivate it, we could have a high quality and much less costly system of medical care.

There are encouraging signs in California. California Public Employees Retirement System just announced that next year's rate will be down 1.1 percent from last year. But we have had competing health maintenance organizations in California for years. Nationally, this is not likely to happen in the next five years, and it certainly will not happen under government-imposed global budgets or price controls on premiums because their incentives are all wrong.

So Congress is left with an apparently impossible dream, promised by the President, with the details left to you.

Your task is to reduce costs and expand coverage to some reasonable standard of universal coverage. Any private health insurance system may not be able to ensure every citizen gets covered. Therefore, a definition of universal coverage should be set and adjusted as information accrues below 100% – just as we consider 95% to be "full employment" – and this should be our goal. Targeted programs can care for those remaining uncovered.

The only way to cut cost without cutting quality is by getting the incentives right. Reform must create powerful market forces that reward doctors and hospitals for forming and operating increasingly efficient comprehensive care organizations, through a long-term continuing process of quality and productivity improvement. The Jackson Hole Group, of which I am a trustee, is preparing a paper entitled "Managed Competition II", which I would like to submit in the next few days as part of my testimony, that describes what I believe is the wisest way to proceed. It takes into consideration the current political context; it does not put the federal budget at risk; it does not undermine positive private sector reforms already underway; and it is consistent with the principles of managed competition.

A critical part of creating appropriate incentives is a limit on tax-free employer contributions to health care, and employers' level dollar-defined contributions, so that anyone who chooses a plan that costs more than the least costly, pays the full difference with net-after-tax dollars, so that the health plan that cuts its price by a dollar sees the whole dollar offered to the subscriber who joins it. The present tax treatment implies a heavy tax on cost containment. The uncapped tax break is a bleeding artery in the federal budget, estimated at $90 billion in 1995 by the Joint Committee on Taxation. A "tax cap" offers the best source of revenue to pay for badly needed subsidies that will help access for the poor. And it does so by broadening the tax base rather than by raising marginal tax rates.

To simplify matters, Congress could pick a national average amount – some amount per individual, per couple, per single-parent family, per two-parent family – that, when adjusted for regional variations in factor prices (like Medicare's Prospective Payments), would approximate the price of an efficient health plan in each region, trend it forward by growth in per capita gross domestic product, and make that the limit on tax-free employer contributions. Then dedicate the savings to subsidies for low-income people.

Managed Competition II describes a limit set at the average priced plan, combined with a tax free health spending account for the cost difference for those who choose a plan priced below the tax cap. A tax cap plus Medisave accounts would preserve the integrity of the incentive. However, while raising the level of the tax cap might be more politically attractive, it also will reduce revenues to the balanced health security budget, making it more difficult to fund low income subsidies. This is particularly important if we want a reasonable benefit reduction rate for low income subsidies to prevent a steep marginal tax rate cliff.

The benefit reduction rate (or implicit marginal tax rate on earnings) when combined with other welfare programs can be unacceptably high. However, the cost of ameliorating the marginal tax rate is also high. Henry Aaron wrote that the Breaux-Durenberger bill would inflict an 88 percent marginal tax rate on people between 100 percent and 200 percent of poverty. I calculated a somewhat lower, but still unacceptably high, rate, although any phasing-out of subsidies represents an improvement over the current Medicaid program. Senator Chafee would ameliorate this by stretching out the zero subsidy point to 240 percent of the poverty line. That would help, but it will also cost more. This is, of course, the painful dilemma that faces all programs of assistance to low-income people. It is very important to consider this health care problem in the context of welfare reform and the total picture of low-income assistance.

A limit on tax free employer-paid health benefits is an excellent source of revenue for subsidizing the poor and reducing the marginal tax rate cliff. A tax cap set at the low priced plan could raise $16 billion per year according to Congressional Budget Office estimates; a cap set lower could raise even more.

A critically important part of total reform is including Medicare and Medicaid in the reformed system. They are too large to leave out, and potential savings in these programs might be used for low income subsidies. Both of these programs are largely frozen into the obsolete and discredited system of fee-for-service, solo practice and remote third-party payment, with all its perverse incentives. These programs perfectly illustrate the words of Vice President Gore in the 1993 National Performance Review: "The federal government seems unable to abandon the obsolete."

Government should get the costs of fee-for-service Medicare under control by Prospective Payment and Volume Performance Standards on a regional basis. Then it should aggressively market enrollment to Medicare beneficiaries in Accountable Health Plans covering the full standard benefit package. In areas where competition has driven premiums below Medicare's fee-for-service equivalent, government should pay in full the price of the low-priced plan. That lets Medicare beneficiaries share in the savings in the form of expanded benefits. In areas where the low-priced plan's premium exceeds Medicare's fee-for-service equivalent (Medicare rates should be utilization-adjusted community rates), government would pay the latter, and beneficiaries who wanted to pay the difference would be free to do so.

What about mandates? We already know a great deal about the pros and cons of several forms of mandates.

An employer mandate, to which I was previously sympathetic, is attractive because it seemed to offer continuity with the present in that it would maintain employer-based coverage. And incrementalism is one of the first laws of our democracy. Moreover, we need a group basis for health insurance, and while the employment basis has its shortcomings, the only apparent alternative would be government and that would be worse. Furthermore, problems of employment-based health insurance in small groups would be mitigated by Breaux-Durenberger health plan purchasing cooperatives.

Under the Administration's version, an employer mandate would also allow the government to shift some of the burden of public programs onto employers and to create the perception that no one is paying the price. However, employer-paid health insurance is a myth; any mandate on employers would be shifted to employees through reduced wages or loss of jobs.

In a competitive economy, the employer can pay no more in total compensation than the value of the employee's contribution to the output of the firm. So if a mandate requires the employer to pay, say, $2,000 in health care, the employer will have to reduce pay or benefits by that amount, unless that would drive pay below the minimum wage, in which case, the employee will be laid off. The cost will not come out of profits in the long run because capital is mobile worldwide and will move to seek a competitive return. Some may be shifted forward to customers, but not much, especially in low wage industries where demand is very elastic.

So the cost is shifted to the employee. Alternatively, the mandate can be a large increase in the minimum wage. Although it is impossible to measure the economic dislocation an employer mandate would cause, clearly some employees would lose out. While some studies suggest not many jobs would be lost, I am skeptical about that in the case of a $1 per hour increase.

An employer mandate may also be very costly to enforce – there are millions of employers. Employers and employees may conspire against the mandate (as in Social Security). I understand Hawaii's mandate has barely brought their coverage to a higher level than some non-mandate states when you control for the relevant explanatory variables.

Also, the Clinton plan subsidizes large firms with well paid people to get them to subsidize their low-income workers. It would be more efficient to target subsidies to low-income workers directly.

I am increasingly impressed by the merits of an individual mandate which requires individuals to purchase coverage. Such a mandate makes sense in that subsidies are targeted at individuals as well. An individual mandate would not motivate employers to cut pay or lay people off.

But this approach has problems too. There is a risk that companies that are currently active, value-based health purchasers will cease these activities and will perform only the minimum duties necessary to fulfill the obligation to offer coverage. However, competitive forces in the labor market and a rule that coverage must be obtained through the appropriate sponsor (the employer in the case of a large group) should maintain an active employer role.

An individual mandate could be enforced through a free rider tax that would require individuals who do not purchase coverage to pay a tax equal to the cost of coverage plus a penalty. A free rider tax could be progressive and enforced by the IRS.

A combined approach, where employers in groups of more than 100 face an employer mandate, individuals in groups of 100 or less face an individual mandate, and low income individuals are targeted for subsidies, is also possible. This approach best builds on the current employment-based system because 99% of companies above the 100-person threshold currently offer coverage to their employees; the percentage of smaller companies is much lower. Potential gaming around the threshold could be mitigated by phasing in with firm size the percentage contribution required of employers. Low income subsidies would still be targeted at individuals because this is the most equitable and efficient approach. And individuals would use their subsidy vouchers either through their large employer or their local health plan purchasing cooperative to defray the cost of coverage.

What to do? I believe that legislation should require every one to contribute toward the cost of their health care and should finance those unable to pay for themselves through a system based on efficient, progressive taxes. However, given that it will take time to build strong health plans, to evaluate progress, to accumulate savings from managed competition, and to allow individuals to avail themselves of the reformed system, it is not inappropriate to fix the system first before agreeing to pour unlimited sums of money into it – the error that was made in the creation of Medicare and Medicaid. Despite the evident problem of a high benefit reduction rate, Breaux-Durenberger represents a very large step forward in terms of coverage of the poor. It would be a worthy point of departure.

Congress should create a balanced Health Security Budget for payment of care for its beneficiaries, including assistance to low-income individuals. A budget would guarantee federal coverage costs do not grow faster than revenue. Government health expenditures would be disbursed on a pay as you-go basis. Medicare and Medicaid would be included in a reformed system in order to increase federal revenues available for subsidies. If savings are not sufficient, legislators would agree either to raise enough money to pay for the standard benefits for the federally covered population or limit the scope of the benefits package or the subsidies available to individuals to help pay for them. Such an approach would ensure that the federal budget is not at risk for open-ended entitlements and that specific segments of the population do not bear excessive cost-shifting. Set a tax cap at a level that saves, say, $20 billion. Consider including tax revenues lost from the exclusion as part of the same budget. As a nonsmoker, I recognize the health policy case for a cigarette tax.

A balanced health security budget alleviates the need to rely on cost estimation models that are, at best, unreliable predictors of future costs. There is great uncertainty in any forecast of health expenditures several years in the future, especially when we are considering very large changes in the system. You should take little comfort from the similarity of the White House, CBO, and Lewin-VHI forecasts. For one thing, they all make the unrealistic assumption that Congress and the courts will resist public and legal pressure and uphold the President's unrealistic price controls on premium growth, even in the face of hospital closings, unemployed doctors and nurses, and patients kept waiting or denied care, etc. And they all use other conventional assumptions – doubtless the best that can be done – about behavioral changes for which there are no or out-dated data.

Then set in motion the process of value for money competition among Accountable Health Plans. As savings are realized, expand the low-income subsidy program within the context of the balanced Health Security Budget. Set a target date by which a goal – such as 97 percent coverage – is to be achieved. If it is not achieved by then, commit the Congress either to raise more money for low-income subsidies, or to impose a mandate. That would give you time to observe progress, see what works and what does not, to more clearly identify the source of non-coverage, and to adopt specific remedies. Whether and in what form a mandate is necessary will become clearer, so some flexibility should be retained.

WHAT'S WRONG WITH CLINTON'S HEALTH CARE PRICE CONTROLS?

[Alain C. Enthoven and Sara J. Singer]

The Congressional Budget Office estimates of the cost of the Clinton Administration's health care reform proposal assume that price controls will work as advertised. They won't, and the cost to the American public of the Health Security Act could be much greater than the $70 billion deficit increase projected by CBO.

Clinton sets overly ambitious targets for spending limits in the private sector. In 1996, per capita premiums can grow by no more than 1.5 percent above general inflation; reduced to inflation by 1999. These growth rates are much below even Canada's and Britain's. If market forces do not meet these targets, government price controls will be applied. Price controls, however, will themselves fail as they have done every time they have been tried, and government will be forced to give them up or to become the sole purchaser of health care for all.

The main trouble with such controls is that they create the wrong incentives for health plans. Management and workers see no serious reward for innovating to reduce cost, so they do not do it. Under price controls, revenues increase only when the government allows it—therefore from political action—and not from improving quality, cutting cost, and satisfying customers. The incentive is to take full advantage of every allowed increase, then fight for more. The best way to make a case for more money is to do a poor job with what you have.

Price controls also fail because they must be enforced by politicians. Brookings economist, Charles Schultze explains: government cannot be seen as directly harming individuals, e. g., by throwing them out of work. Thus we find it extraordinarily difficult to close unneeded military bases, post offices and schools. On the other hand, people regularly accept plant closures and layoffs if caused by impersonal market forces in the private sector. That happens every day. If the government were to stick to its zero real growth target, health insurance plans would be forced into insolvency, millions of people forced to change health plans and doctors, thousands thrown out of work. Let government controls force a hospital or health plan into bankruptcy and Congressmen will be deluged by irresistible pleas for relief. There is no way for Congress to commit not to respond to constituent pressure, so inevitably it does.

If politicians were able to resist constituent pressure, price controls would still fail to reduce health care costs for legal reasons. The Fifth Amendment to the Constitution prohibits the government from "taking" private property without due process of law and just compensation.

The due process clause generally requires that price controls be set, and adjusted, through fair procedures. This can be done through providing extensive, individualized hearings to set a fair price for each health care provider. This kind of price regulation eats up enormous amounts of both time and money, even when applied to a relatively small number of companies and products. Applying that kind of procedure to over a thousand health plans all over the country would be very costly indeed.

Thus the political and the legal reasons lead to the same result: government price controls cannot force companies out of business. To ensure business survival, government must allow for a "fair rate of return" which means that if costs go up, revenues have to be allowed to go up by the same amount. Unfortunately, such cost reimbursement is very inflationary, rendering price controls ineffective as a way of containing costs.

The government could attempt to violate the requirement that it not take private property, in this case the businesses of the health insurers or health care providers, without just compensation. The Supreme Court has held that regulation that prevents a firm from making a fair return on its investments will be considered a "taking" if it "goes too far." Just how far is too far remains a difficult question for the Supreme Court. Rulings on such cases might be tied up in court for years. For example, California voters passed Proposition 103 in November 1988, mandating a 20 percent roll back in auto insurance premiums. Over five years later, implementation is still tied up in court over the issue of fair rate of return.

The Clinton bill seeks to avoid testing these limits with perhaps its most extraordinary provision. In Section 5232 of the proposed legislation, it attempts to eliminate all administrative and judicial review of any statutory or constitutional questions raised by the price-setting roles of the National Health Board or the Regional Health Alliances. No health care financing and delivery plan in the United States would have constitutional protection against government taking its business (i.e., setting rates that force them into insolvency) without due process and just compensation. This is one way, unattractive though it may be, to prevent a repeat of California's experience with Proposition 103. This kind of effort to prevent all review

of this kind of government action seems unprecedented. It has been upheld with respect to some limited provisions in a few government benefit schemes, but never for a scheme of industrial regulation.

One theory behind this suspension of the takings clause stems from the "entitlement" provision of the Clinton bill. Every legal resident is entitled to the full federally-defined comprehensive package of benefits. In this way, the whole health services industry becomes a government benefit program, and the government can determine the terms on which it purchases and confers benefits. Government is always an ineffective purchaser, especially in something as complex and subtle as medical care. Experience with Medicare has shown government cannot deal with issues of volume, quality or appropriateness of services. People in the health services industry who are not yet alarmed by this ought to be. This comes close to nationalizing the industry.

In the Clinton bill, the federal government assumes the risk for premium increases in excess of wage increases. So the government will be under pressure to promulgate whatever regulations it must to slow cost growth. There are no provisions for micro management by the federal government yet, but when global price controls fail, regulators will resort to ever-more detailed regulations as to what are allowable costs, investments and health practices. Everyone in the industry will, in effect, become a federal functionary, constrained by thousands of pages of laws and regulations. If the effort to shut off all review of these decisions is held constitutional—a questionable matter—it would put the health care industry in a bizarre and untenable situation. It would face not only the uncertainty and political risks of any regulated industry, but would face them without the assurance that someone outside the regulatory agency would eventually review the fairness of the rates.

If government were to take such control of the health care system, ours would become like the health care systems of Britain, Canada, and Sweden, and the public school and criminal justice systems in this country—all chronically underfunded and underperforming, because they are rigid government monopolies with no incentives to innovate to improve quality, effectiveness and efficiency.

Here are some likely consequences.

First, there would be deprivation of much of the most effective medical technology: one CT or MRI scanner per region, often without enough money to operate it full-time. Many people would be diagnosed and treated without the best technology. People whose lives can be extended by renal dialysis would find treatment unavailable, etc.

Second, there would be long waiting lines, often two years or more, for bypass graft surgery, hip replacement, and cataract removal. These delays are especially hard on the elderly who need these procedures more frequently and urgently than younger people. Restraining national health expenditures is not at all the same as reducing the cost of illness and its treatment. Long waiting lines amount to shifting the costs of untreated illness back onto the untreated patients and their families.

Third, private investment in the industry would dry up. Few would invest their capital and effort without constitutional protection of property rights. Capital is mobile worldwide. People who might have invested in new medical information systems in the U.S. can instead invest in factories in Thailand or Mexico. Government would have to supply the capital, which implies the usual waste and excess of pork-barrel politics.

Fourth, health professionals would become alienated and embittered by government-forced roll backs in their incomes. Strikes and strife, such as Ontario's extensive physician strikes, would be the order of the day. While it is uncertain whether government will be able to take private property without due process and just compensation, it is certain that the government cannot compel the provision of willing, high quality, patient-friendly medical care services.

The great irony in all this is that such controls are not necessary to restrain health expenditures. Maximally effective market forces could do the job better in a system that remains private enterprise and that relies on empowerment rather than entitlement. Indeed, the only forces known to man that can motivate true cost reduction are competitive market forces, i.e., powerful incentives to innovate to make treatments more effective and less costly.

Already, today's weak market forces are transforming the health services industry, forcing cost-reducing consolidations, and accelerating ?he growth of HMOs. Three relatively simple but powerful steps to strengthen market forces and accelerate this process are:

First, formation of health plan purchasing cooperatives nationwide to allow all individuals and small employers to pool their purchasing power, spread risks, and offer consumers a choice of plan.

Second, a limit on tax-free employer premium contributions, coupled with a requirement that employers offer employees a choice of plan and make defined dollar contributions toward the plan of the employee's choice, so that employees who choose more costly plans must pay the full premium difference with after-tax dollars. This would maximize the incentive to seek value for money.

Third, use of the budget savings from the "tax cap" and existing state revenues now used to pay for care for the uninsured to subsidize purchases of health plan coverage by all low-income people, perhaps with incomes up to twice the federal poverty line.

The Cooper-Grandy, Breaux-Durenberger Managed Competition Act of 1993 does all this. The provisions of this bill should be blended with some combination of individual and employer mandate to achieve universal coverage.

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PREPARED STATEMENT OF MICHAEL J. GRAETZ

Mr. Chairman and Members of the Committee: It is a great pleasure to appear before you today to discuss the subject of health care reform. I offer this testimony on behalf of myself and my colleague, James Tobin.

The Committee has asked that we focus today on the appropriateness of mandating health insurance coverage and, in particular, on the relative merits of employer and individual mandates. We also offer here our specific approach to health care reform for the Committee's consideration.

First, we believe that all Americans should be entitled to receive adequate medical services without regard to their ability to pay or their health status. Universal health insurance, like universal auto accident insurance, requires that coverage be mandated. We believe that the legal requirement ought to be directed to individuals, not employers.

It is individuals who get sick and need medical services. Individuals' and families' ability to pay is the natural criterion of equity. It is individuals who must be guaranteed coverage. So it is individuals who must be required to have insurance.

In our view, the impetus for mandated employer health coverage is not grounded in a vision of the best way to pay for or provide health insurance, but rather reflects excessive solicitude for existing institutions and interests and an effort to avoid the political difficulties of abandoning the status quo. If government is to accept the responsibility for assuring all Americans health insurance—as it assures their national defense, roads and sidewalks, parks and libraries, and elementary and secondary education—it is simply bizarre public policy to link health insurance to employment and then fill in the gaps for those who are temporarily or permanently out of the job market for example, because they are children, unemployed or retired.

The only sensible reason for linking health coverage to employment is that much health insurance coverage is now provided through employment. In other words, employer mandated health insurance has far less to do with where we should be taking health care reform than with where we are now. And this particular form of incrementalism threatens to squander this historic opportunity to reform this nation's system of financing and providing health coverage. Expanding, rather than abandoning, employer-based medical insurance increases the risks that major health care reforms enacted today will fail in the long run to provide the secure, portable, adequate, reasonably priced, and universal medical care that we all want.

Employer-based medical insurance is an historical accident—one that no one would choose now if we were beginning with a clean slate. During World War II, employers and unions circumvented federal wage ceilings by offering medical fringe benefits. The popularity and generosity of employer-provided health insurance boomed after the war, because Congress sheltered them without limit from income and Social Security taxes. To be sure, the first compulsory health insurance bill introduced in the United States Congress in 1916 was employment-based, and a similar bill was considered by the New York state legislature in 1919. But whatever the merit of employment-based insurance at the beginning of this century, it commands little logic as we enter the twenty-first century. President Clinton has emphasized the need for individuals to develop skills and become flexible in the face of the changeable modern job market. He points out that workers now should expect, on average, to change jobs eight times, but he fails to recognize the irony of attempting not only to sustain, but indeed to expand, employer-based health insurance as America moves into the twenty-first century.

The principal political advantage of requiring employers to pay for their employees' health insurance is that it hides who bears the actual costs of that insurance. The fact that employers write the checks for medical care does not mean that they bear the full costs. In the long run, costs are generally shifted to workers through reduced take-home pay, and perhaps, to some extent, to customers in higher prices. Many health reform proposals currently before the Congress place large administrative burdens and impose substantial hassles on ordinary people by insisting on deductibles and co-payments, even for the poor, on the ground that cost containment demands that people clearly face economic costs each time they obtain medical care. But these same proposals disguise the true economic costs of obtaining health insurance coverage by imposing the legal requirements of payment on businesses rather than people. This seems to us a serious mistake.

Finally, let us not be deceived that the choice is between an employer mandate and an individual mandate. As the Clinton's health reform proposal (and all others that mandate employers to buy health insurance for their employees) makes clear, an employer mandate also requires an individual mandate. Under the Clinton bill, all employees would have to contribute 20% of the cost of their own coverage, a requirement which in most cases, would be enforced through wage withholding. But low income individuals, unemployed and retired persons and others temporarily or permanently out of the work force are also required to participate in the system, and the government must track these individuals and their payments, and determine whether or not they are eligible for subsidies. Moreover, Native Americans, veterans, and Medicaid and Medicare recipients all would enjoy different government subsidies under the Clinton plan, based upon their status and, in some cases, their incomes. Thus, the choice is whether to have a mandate only on individuals or on both individuals and employers—not, as members of the Administration often suggest, whether to put mandates on employers instead of individuals.

Let us now discuss separately the two aspects of the employer mandate: administration and financing.

Administration. There appear to be two administrative advantages in the desire to link health insurance and employment. First, collection of health insurance premiums can be facilitated through requiring employer withholding and requiring employers' either to use the funds to pay for the employees' insurance or to deposit payments with the IRS or directly with a health insurance agency, such as a health alliance or health insurance purchasing cooperative ("HIPC"). Second, a variety of health insurance plans can be presented to individuals at their place of work and they can select which coverage to buy there. Both of these administrative advantages can be realized whether or not any burden of employer financing is imposed. Indeed, legislation now before this Committee that mandates individual coverage does achieve these advantages.

Financing. Proponents of employer-based financing seem to see two principal advantages: First, it locks into place existing payments made by employers who now provide health insurance for their employees. Second, it hides the costs of financing additional coverage, since wage earners and consumers fail to understand the economic burdens of employer-financing on themselves and instead believe that these burdens are borne by someone else. The first of these benefits—locking in existing employer contributions—can be retained through a transitional requirement that employers who now provide health insurance to their employees be required to continue to do so—a maintenance of effort requirement—or to demonstrate that they have substituted an equivalent amount of cash wages. As we have suggested earlier, the second alleged advantage is in fact a disadvantage. One of the major problems with the existing system of financing health insurance in this country is that it hides much of the costs. This invisibility has contributed to rising costs.

On the other hand, there are many disadvantages to employer-based financing. First, for employers who want to circumvent such a mandate, there are incentives to use part-time workers, temporary and seasonal help and overtime, to engage in cash transactions off the books, to hire single persons rather than heads of families, and to classify people as independent contractors rather than employees. Second, coupling employer-financing mandates with employer-based subsidies inevitably produces inequitable and arbitrary results. Indeed, the very notion of equity across employers is itself something of a non sequitur. Subsidies inevitably will depend upon the size of the business and will create a variety of disincentives for hiring additional employees. For example, at whatever breakpoints are selected—50 and 75 employees under the Clinton plan—the marginal costs of hiring an additional worker often will be prohibitive. Moreover, under the Clinton plan, as both the Congressional Budget Office and the Joint Committee on Taxation have pointed out, economic segregation of employees will be promoted. High income workers will be advantaged by working for businesses whose cost caps are the cost of insurance, rather

than percentages of payroll. Low income workers will face exactly the opposite incentives; they will be driven toward plans where the employer's contribution is capped as a percentage of payroll. Individuals will be treated differently based upon the type of employer for whom they work and on that employer's circumstances. The adverse consequences of employer mandates will be greatest for marginal businesses and marginal employees. Finally, families will be treated differently, depending on the number of employed members, whether they work full or part-time, and how often they change jobs, work locations or places of residence. A flat rate payroll tax on employers would have major substantive advantages over the complex system of mandated payments and wage caps of the Clinton plan.

We agree with those who believe that the aggregate effects on employment of employer mandated health coverage would not be large, if coupled with controlling health insurance costs. But the inequities and economic inefficiencies at the individual and firm level will be serious. They could easily be avoided.

Individual Mandates. The advantages and disadvantages of individual mandates are, to a large extent, a mirror image of those of employer mandates. With regard to financing, equity demands that public subsidies, whether direct or through employers, be a larger share of premiums and income for poorer families. Equity also requires that if families' incomes and circumstances are the same, their subsidies should be the same. But any employer-based system of financing and subsidizing health insurance will necessarily violate these principles of equity. With an individual mandate, government contributions to the cost of health insurance can be targeted based on income and need. And an individual-based system can—and should—treat self-employed people exactly the same as employees.

The major concern with individual mandates seems to be about administering the system. However, in understanding that matter, it is important to remember that tracking individuals, their payments and subsidies, and their health insurance coverage cannot be avoided by mandating employer financing. The problems of enforcing an individual mandate do not simply disappear by coupling an individual mandate with an employer mandate as under the Clintons' plan. Enforcing a requirement that individuals have health insurance is an essential element of any reform that attempts to achieve universal coverage.

There are a variety of ways to approach the administrative issues. First, the major expansion of the earned income tax credit in the 1993 Budget Act means that the Internal Revenue Service will now have contacts with many poorer Americans who previously were outside the income tax system. This creates a new ability to use the IRS both to deliver subsidies and enforce mandates without great expansion of that organization's size or capacity. In addition, hospitals and other medical care providers can also help to enforce an individual mandate by making sure that individuals are enrolled whenever they obtain medical care. Finally, to the extent that the states are to be involved in the administration of the health reform effort, a number of additional enforcement possibilities are presented. For example, state unemployment offices and welfare offices could play an important secondary role in both enforcing individual mandates and delivering individual subsidies. Indeed, states might even require evidence of health insurance as they now do for auto insurance when people obtain drivers' licenses.

It is important to be realistic about the limits of law enforcement in this context and to recognize that neither an employer mandate nor an individual mandate (nor a combination of both) will be perfectly enforced. Enrolling people who are the most difficult to reach, such as children, unemployed individuals, domestic workers, and the self-employed will be difficult under any system.

An important additional advantage of an individual mandate is that de-linking health insurance from employment creates opportunities to produce a truly portable system of health insurance geared to workers in a twenty-first century economy without regard to whether they work at home or in a traditional office, how often they change jobs or move their places of residence. Finally, an individually based system enhances personal privacy and improves the ability of people to choose where they buy their health insurance and where and how they obtain their medical care.

We have suggested elsewhere that one health insurance option available to all Americans should be like Medicare for those under age 65. We have called it Fedmed. Fedmed would offer the basic universal medical insurance package at premiums that in total would cover the costs. The federal government might also extend to any American the choices now available to its employees under the federal employees health insurance system ("FEHB"). Then anyone could purchase health insurance through a system that offers a great range of health insurance plans in virtually every locality. Private health plans could also offer the same basic package of health care benefits, but no one would be allowed to pick and choose members

or to charge greater premiums for more risky individuals or families. As in the Clinton plan, it would no doubt be necessary—not to say easy—to collect money from plans that turn out to have low-risk clienteles and redistribute some of these amounts to plans with high risk members.

Federal subsidies to individuals would take the form of refundable tax credits or "vouchers" payable to Fedmed or other insurers. If something new and unstigmatized were desired, these subsidies could even be in the form of health insurance credit cards that could be used to obtain tax refunds which then would be transferred directly to health insurance providers or used to purchase health insurance.

For low-income families, the subsidies would cover the whole premium of the basic package. Most other families would receive vouchers at least as valuable to them as the current tax exemption for employer-provided insurance. A family of four in the 28 percent tax bracket with a $4,300 insurance package would receive tax credits or vouchers of at least $1,204—28 percent of the premium. No family would face an out-of-pocket cost of more than 10 percent of their income for the basic package.

This plan would not require new broad-based taxes or new burdens on employers. One source of financing would be redirecting the Clintons' proposed subsidies to employers and low-income people, estimated at $100 billion in 1999 (somewhat more by the Congressional Budget Office). Eliminating the tax shelter for employer-paid premiums would contribute $125 billion, and our plan would replace Medicaid acute care for those under 65 ($75 billion more).

Let employers help pay the premiums if they wish, but count those payments as taxable income. Finally, employers who now offer coverage to their employees could be required to continue to offer such coverage during a period of transition. During that period, only if employers are able to show that they have substituted cash wages for health insurance would they be allowed to drop health insurance coverage.

But people's health insurance, like their auto insurance, their life insurance, and their fire and other casualty insurance would be owned by themselves, not by their employers.

An individual mandate offers great flexibility about the institutional arrangements through which people might obtain insurance. If Congress so desired, health alliances along the lines that President Clinton has suggested could be created. Or, voluntary health insurance purchasing cooperatives along the lines proposed by Senator Chafee, Senator Breaux and others could form.

By requiring the federal government to offer Medicare-like coverage to all Americans as well as health insurance now available only to federal employees and by explicitly limiting the growth rate in the per capita costs of these federal programs in the legislation, the need for caps on private insurance premiums along the lines of the Clinton Plan could be avoided. People could change health insurance plans annually. If private costs rise faster than the government options, people will select from the government's menu. On the other hand, when the private sector is more successful at keeping costs down and quality up than the government, people will shift to private plans. Moreover, the budgetary scorekeeping role now being played by premium caps should become unnecessary. The government will have to keep its own house in order—a large enough chore—but price controls would become unnecessary surplus.

Our proposal is not a radical reconstruction. It builds on the best of existing institutions and would create a stable and equitable system for the future. It borrows features from plans offered within the Congress across the political spectrum, but unlike some of them, it makes certain the achievement of universal coverage. A victory for it would be a victory for the American people and a demonstration of effective bipartisan governance.

PREPARED STATEMENT OF SENATOR ORRIN HATCH

[March 15, 1994]

Thank you Mr. Chairman. It is certainly a pleasure to have before us today this panel of noted experts in the field of health care and I look forward to their testimony.

One of the fundamental aspects of this debate is the task to reduce health care costs while expanding coverage to those Americans currently without health care insurance. I welcome the comments of our witnesses who will provide us with some very specific recommendations on financing expanded health coverage.

Indeed, one of the central and more controversial aspects of the Clinton proposal is the employer mandate which requires employers to Provide health insurance coverage to their employees and to pay 80 percent of the costs. I look forward to your analysis and recommendations on this component of the President's plan.

I for one have strong misgivings about an employer mandate as a means of securing universal coverage.

What other mechanisms can be implemented that secure the needed funding without imposing additional costs on employers?

Health care security for all Americans is central to the national debate on health care reform. But we must also keep in mind that fundamental restructuring of the current system may lead to the imposition of new costs which may prove as damaging to those whom we want to help.

These costs could very well translate into wage reductions and job loses. And, I do not think this committee wants to revisit the issue several years from now, after the damage has been done, to correct what was done in this Congress.

That is why I am particularly pleased to have this distinguished panel of witnesses before us because they represent some of the preeminent "thinkers" on health care.

Once again, Mr. Chairman, thank you for assembling this panel.

Prepared Statement of Senator Orrin Hatch

[March 17, 1994]

Thank you, Mr. Chairman. Briefly, I just want to welcome our panel of witnesses here today, and let them know how much I appreciate the considerable time and effort they, and their organizations, have obviously devoted to developing their respective statements. I was very impressed by the level of specificity and substance with which each of you have presented your arguments.

You have made some very compelling points which underscore the difficulty, and complexity, of financing universal health care for all Americans. It also underscores the difficulty the Committee is going to have in finding a consensus on this issue. I was particularly impressed by a statement in the prepared testimony of Mr. O'Flinn from the Mobil Corporation. I would like to quote from page two of his prepared testimony because it so clearly and succinctly summarizes what I see as a growing concern among people who talk to me about health care reform.

He states: "With 15 percent of the economy at stake, we cannot afford to make major mistakes in evaluating, designing and implementing health care reform. We cannot afford grand experiments that risk spectacular failure. We need to take what we already know works, create strong incentives for its expansion, and grow into a reformed health care system, to accomplish the President's laudable goals, on a defined timetable."

Mr. Chairman, I make this point because it also serves to underscore the fair and equitable manner in which you have conducted these hearings, and the fact that you have presented a balanced and credible list of witnesses in the course of our Committees hearings.

I thank you for that, and once again, wish to welcome our panel of witnesses.

Prepared Statement of John Holahan [1]

I appreciate the opportunity to appear before this Committee to discuss the issue of employer vs. individual mandates. The major health reform proposals (except single payer) that would eventually provide universal coverage rely on one or the other approach or both. The Clinton Administration's health reform plan is structured around a combination of employer and individual mandates. Employers are required to pay 80 percent of a composite premium, with a cap at 7.9 percent of payroll. Caps at lower percentages of payroll are proposed for smaller low-wage firms. There are also caps on individuals' responsibilities that limit their contributions as a percentage of income. The major alternative for eventually providing universal coverage is to rely exclusively on an individual mandate, as proposed in the Thomas/Chafee bill. This approach makes all individuals responsible for their own insurance coverage, with subsidies eventually available to all below 240% of poverty.

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[1] The views expressed in this statement are those of the author and do not necessarily represent those of The Urban Institute or its sponsors.

In this testimony, I discuss the advantages and disadvantages of both approaches. I believe neither in their pure form will work in the United States and suggest a way to blend the two to develop a workable solution.

WHY A MANDATE?

Mandates are required to obtain universal coverage because the incentives to avoid purchasing insurance policies for many Americans are simply too great. Health insurance is expensive and, for many, simply unaffordable. For others, especially the young and healthy, the benefits do not seem to be worth the cost. And a system of free catastrophic coverage is available through care provided by many of the nation's hospitals. But the rest of Americans pay for the costs of the uninsured through higher health care premiums that finance this free care.

All Americans, depending on ability to pay, should be required to contribute to financing the health care system; there should be no "free riders."

Moreover, the present system of free care is being eroded. As private managed care plans, Medicare, and Medicaid all become more aggressive in their efforts to contain costs, the ability of hospitals and other providers to pass these costs along to other third-party payers is quickly being eliminated. Without universal coverage, the ability of the system to provide care to all Americans through its hidden catastrophic care system will not be there in the future the way it has been in the recent past.

AN EMPLOYER MANDATE

The primary argument for an employer mandate has been that it builds upon the current system of financing and administration. It is, therefore, less disruptive because it largely uses the same source of revenues as well as much of the same administrative capacity that are used today.

It extends the financial responsibilities of employers to businesses that are not now providing health insurance. In so doing, it "levels" the playing field, giving all employers similar if not identical responsibilities.

The second advantage is that, compared to an alternative such as a single payer system, there is less cost to the government. Because some of this cost is borne by business, at least initially, there are fewer explicit new taxes. Comparisons of government costs under employer and individual mandates are difficult because the results depend on how each is structured. The Clinton plan's version of an employer mandate, with an 80% contribution, has relatively high government costs because of the subsidies required to protect small low-wage firms. But individual mandates that have very generous subsidies to the poor and near poor could mean even higher government costs.

A final advantage of an employer mandate is that it is easier to enforce than a mandate imposed on individuals. This is especially true in a system that would rely on relatively large mandatory alliances. Employers could be required to make periodic contributions and to withhold the employees' share along with income and payroll taxes. A substantial amount of money is already collected in this way for other purposes. Contributions by non-workers would require a different mechanism, but it would only apply to a small share of the population.

There are several disadvantages to an employer mandate. Perhaps the greatest concern is the potential adverse impact on small business and on employment of low-wage workers. The long-run effects of mandates on employers are generally exaggerated, but the short-run problems are real and merit attention. A large share (about 40%) of working Americans without health insurance are employed by small business (those with under 100 employees). These firms will face higher costs because of the mandate. But most research evidence suggests that these employers will not really bear the costs in the long run.[2] Rather, employers will shift the costs to workers through lower wages and reductions in other fringe benefits. Some businesses may increase prices rather than reduce labor compensation. Because employers will shift these costs to others, an employer mandate is unlikely to have much of an effect on jobs in the long run. The more likely effect of an employer mandate is to reduce (or slow the growth in) wages of those workers who would newly receive health insurance.

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[2] Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (Washington: U.S. Congress, 1994); Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance," *Tax Policy and the Economy* (1990); and Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* (forthcoming).

Because it takes time for business to adjust wages and/or prices in response to a mandate, it could threaten the jobs of low wage workers and perhaps the survival of some small businesses in the short run. These possible effects require either a slower phase-in of the mandate for small employers, subsidies for small low-wage businesses, or a lower employer contribution.

While these wage and job effects are indeed likely to occur, it is incomplete to ignore other changes that will also occur. First, for many employers, labor costs will fall because they will no longer have to provide coverage for many dependents who will now receive coverage through other employers, and because their premium payment will no longer contain a hidden "tax" to pay for uncompensated care. Second, labor costs will fall to the extent the system is successful in controlling the growth in health care costs. In both cases, the result will be an increase in the demand for labor by some firms and a resulting increase in either wages or employment or both in other sectors of the economy. In addition, an immediate impact of health care reform in the near term will be to expand health insurance coverage and the use of health care services. Thus, there should also be an increase in wages and employment in the health sector and related industries. Several studies as well as recent reports of the Council of Economic Advisors and the Congressional Budget Office suggest that the overall effects on employment are likely to be small.[3]

The wage losses that will occur indicate one of the real problems with employer mandates. Because employers pass the cost of insurance on to workers in the form of lower wages, an employer mandate is largely a tax on workers. Because the "tax" does not vary with income, it a. also a very regressive tax. That is, it represents a higher percentage of income for low-income workers than for high-income workers.

One way to address the potential adverse effects of employer mandates is to provide subsidies to small low-wage firms, as the Administration has done. In firms with more than 75 workers, employer contributions are capped so that premiums cannot exceed 7.9 percent of payroll. Premiums for smaller low-wage firms are capped at smaller percentages of payroll.

In reality, these subsidies are poorly targeted and likely to generate economic inefficiencies and administrative complexity. As they are structured, the subsidies will go to all workers in firms whose premium costs exceed the payroll cap. That is, they will offset the wage reduction that would otherwise occur for all workers, not simply low-wage individuals. In contrast, low-wage workers in firms that are not eligible for subsidies will experience wage reductions without any offsetting subsidies.

In addition, these subsidies will add to the administrative complexity of the system. Alliances will have the difficult task of determining the appropriate subsidy available to each small business. Moreover, businesses have strong incentives to restructure and form new smaller low-wage firms that will be eligible for subsidies or to "outsource" all work that can be done by smaller low-wage businesses. If it were more efficient to contract out for these services, firms would have done so in the first place. The incentives to restructure firms in order to maximize subsidies will reduce economic efficiency and add to administrative complexity.

Perhaps the greatest problem with an employer mandate is that many individuals truly believe the employer is paying for these benefits. As a result, the individual does not feel responsible for the effectiveness of the system. The individual is not likely to believe he has a financial incentive to support his employer or the government, as the case maybe, in their efforts to manage the system, e.g., adding or reducing benefits and cost sharing and controlling costs.

The final weakness of the employer mandate as structured in the Administration's plan is that the incentive for employers to play a major role in containing health care costs is also substantially weakened. This occurs because of the cap on employer contributions. As premiums grow faster than wages, more and more firms will exceed the cap. They will simply pay 7.9 percent of payroll and be free of any additional obligation. The result is that neither individuals nor employers will have a financial stake in the government's success in containing costs.

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[3] See, for example, Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (Washington: U.S. Congress, 1994); Council of Economic Advisers, *The Economic Report of the President* (Washington: U.S. Government Printing Office, 1994); J. Kiernan and D. Goldman, "Job Losses Due to Health Care Reform" (Santa Monica: RAND Corporation, 1993); A. Krueger, "Observations on Employment-Based Government Mandates, with Particular Reference to Health Insurance" (Mimeo, Princeton University, 1993); Employee Benefit Research Institute, "An Employer Mandate: What's known and What Isn't (Washington, EBRI, November 1993); and Economic Policy Institute, "The Impact of the Clinton Health Care Plan on Jobs, Investment, Wages, Productivity, and Exports" (Washington: Economic Policy Institute, November 1993).

AN INDIVIDUAL MANDATE

Because of these problems with an employer mandate, many have come to believe that an individual mandate may be superior. First, the financial responsibility for obtaining insurance rests upon the individual. This gives the individual a much stronger personal stake in monitoring the health care system. The individual would no longer believe that health care benefits are something provided to him or her by the employer or by the government. Rather, individuals themselves are both beneficiaries and payers.

It is also possible with an individual mandate to target subsidies more directly on low-income individuals, resulting in a more progressive system of financing. And the inefficiencies of employer subsidies are eliminated.

Finally, an individual mandate has no adverse financial impacts on business (though this depends on how the subsidies are financed). Assuming there are no other financial responsibilities placed on business, employers will not attempt to shift the costs onto workers in the form of lower wages or to increase prices. There are no possible adverse effects on employment even in the short term.

The disadvantages of an individual mandate are that there are potentially high costs to low-income individuals because health insurance premiums are expensive relative to income. To reduce the costs to individuals, substantial new subsidies would be required to limit the financial contributions of individuals and families. The government cost of an individual mandate depends on the subsidy schedule and how many employees drop coverage. An individual mandate that provides generous subsidies to individuals and families below 250 percent of poverty could require more new government revenues than the Clinton plan.[4]

One reason government costs would be higher is that many employers who now provide health insurance would cease doing so. For example, if employers stopped providing health insurance and gave workers higher wages instead, workers could buy their own health insurance and low-income individuals would gain government subsidies. The employers continued to provide health insurance, workers would not be eligible for subsidies.

In addition, under an individual mandate, there are higher marginal tax rates on earnings than under an employer mandate, providing serious disincentives to greater work effort. This occurs because individuals lose part of the subsidy as their income increases. For example, the Thomas/Chafee bill would structure the individual mandate so that individuals with income below 100 percent of poverty would pay nothing, while individuals at 240 percent of poverty would pay the full premium. The result is that increased earnings mean rather sharp losses of subsidies. In addition, these individuals would pay payroll taxes, begin to pay federal income taxes and lose earned income tax credits, and pay higher state income taxes. It is estimated that the marginal tax rate would exceed 60 percent in this income range if subsidies were to be phased out at 240 percent of poverty.

The only way to avoid this effect is to reduce the overall value of the subsidy for those below poverty or to phase it out more slowly, giving some assistance to those with incomes above 240 percent of poverty. In the former, the costs to the poor increase while in the latter the cost to the government is higher.

The final problem with an individual mandate is the difficulty in enforcement. The government would have to assure compliance by 225 million nonelderly Americans on a case-by-case basis. While in principle, employers could be required to provide evidence of their employees' compliance, this would be more difficult than under an employer mandate (particularly if alliances are small or voluntary or nonexistent) because individuals would be choosing many different plans with varying premiums and would be required to pay different amounts depending on their eligibility for subsidies. The alternative would be to place the responsibility solely on the government to identify and penalize those who fail to enroll, either through the income tax system or when these individuals try to use health care services.

COMBINING EMPLOYER AND INDIVIDUAL MANDATES

A compromise lies in using both an employer and individual mandate as with the Clinton plan, but with some important changes. First, the required employer contribution should be reduced to 50 percent of the weighted average premium of plans offered in an area, using the composite premium structure of the Clinton Adminis-

[4] This is based on preliminary simulations conducted at The Urban Institute of subsidy schedules that would provide full subsidies for those below poverty, with subsidies declining with income up to 250 percent of poverty. It assumes that most employers of low wage workers would drop coverage. It is clearly possible to design a subsidy schedule that would keep the government costs lower.

tration proposal. Employers could continue to contribute more if they chose to do so. Furthermore, there would be no percentage of payroll cap on the employer contribution.

Because the employer contribution would be limited to 50 percent, the financial burden on employers would be substantially reduced and there would be little or no need for caps on employer contributions. Some small, low-wage firms may continue to need some assistance. But most of the funds that would be used to subsidize employers under the Clinton plan could be used to improve the generosity of individual and family subsidies. For example, all individuals could be subsidized perhaps up to 200 percent of poverty or higher.

The advantages of this hybrid approach are several. First, government costs would be less than under the Clinton plan and under most versions of an individual mandate. The increased subsidies provided individuals and families would be offset by the substantial reduction in the need for employer subsidies.

Second, most of the subsidy dollars could be targeted directly on low-income individuals and families. We have shown elsewhere that the employer subsidies in the Clinton Administration proposal benefit individuals throughout the income distribution including very high-income individuals.

Third, because the employer contribution would be lower, there would be less of a wage loss to workers. Individuals and families would of course be responsible for a higher share of the premium. But the financing system would be less regressive than under the Clinton plan because less of the financing would come through employer contributions, and low-income families would be subsidized directly.

Fourth, by retaining a significant employer contribution, there would still be a low marginal tax rate on additional earnings. The marginal tax rate on additional earnings would be higher than under the Clinton Administration plan, but it would be substantially lower than under a pure individual mandate with subsidies.

Fifth, all firms would be treated the same, with no subsidies that vary by wage levels and firm size.

Sixth, the advantages that an employer mandate has in terms of enforcement would remain. The government would not have to monitor the compliance of 225 million individual Americans on a case-by-case basis.

Probably the most important advantage of this system is that both individuals and employers would have major financial roles in the health financing system. Each individual would have a much greater degree of responsibility for financing his or her family's share of the costs of the system compared with a mandate that has a greater employer share. There would be greater financial incentives to more carefully weigh the benefits of more expensive plans against their costs. Individuals would see more clearly both the benefits and costs of government efforts to limit premium growth. This approach would also keep employers aware of health system costs and, therefore, likely to support cost containment efforts. In this respect it is similar to the German system which requires equal payroll contributions between employers and workers. This equal sharing of costs is often credited by Germans for the strong support given to the government in its effort to contain the growth in health care expenditures.

Prepared Statement of Christopher W. O'Flinn

The ERISA Industry Committee (ERIC) submits to the Committee on Finance, U.S. Senate, the following testimony regarding the financing of health care system reform and the impact of selected health care reform proposals on employer-sponsored health benefit plans.

BACKGROUND

ERIC is a non-profit employer association committed to the advancement of the employee retirement, health, and welfare benefit plans of America's major employers. ERIC represents the employee benefits interests of more than 125 of the nation's largest employers. As sponsors of health, disability, pension, savings, life insurance, and other welfare benefit plans directly covering approximately 25 million plan participants and beneficiaries, ERIC's members have a strong interest in the success and expansion of the employee benefit plan system in the private sector. All of ERIC's members provide comprehensive health care coverage to their employees. Together, they provide coverage to about 10 percent of the U.S. population.

ERIC consistently has articulated the broad consensus among major employers that the keys to making health care affordable for all Americans are, first, a commitment to improve the way health care is organized and delivered with respect to both quality and cost, and second, a commitment to eliminate the cost-shifting that

plagues current health care financing. ERIC's March 1993 *Policy Statement on Comprehensive Health Care System Reform*[1] describes principles and strategies for reform that are consistent with this consensus view. The following ERIC statement is based on this consensus policy document and subsequent discussions within ERIC's membership.

ERIC'S PERSPECTIVE ON REFORM

ERIC recognizes the leadership of President Clinton and the First Lady in bringing health care system reform to the forefront among national concerns and shares their determination for reform. The scope and breadth of the proposal they transmitted to Congress has ensured that no important aspect of health care reform will be overlooked. ERIC also acknowledges the key role of the Members of this Committee, who have consistently pushed the debate forward and have given us and so many others a forum to express our views.

ERIC believes that the current health care system has serious flaws with respect to cost, quality and access to care. Federal governance, not 50 disparate state-by-state approaches, is required if we are to address these concerns in a consistent and compatible manner throughout the entire system. Neither consumers, payers, insurers, nor providers are constricted by state boundaries in the business of health care; thus, it is essential that Congress recognize the interstate character of the health care industry, preserve the principle of federal uniformity and preempt state laws affecting all health benefit plans.

Improving the quality, cost-effectiveness, and accessibility of the current health care system in our country demands focused structural and financial reforms to address its deficiencies. Health care providers must be accountable to third-party payers and consumers for both the quality of their performance and the cost-effectiveness of the services provided. Reform must produce greater value for private and public health care expenditures by improving the consistency and quality of care while managing cost. Failure to do so jeopardizes the affordability of health care coverage, reduces the number of people covered, and undermines the productivity of American businesses.

The success or failure of reform proposals cannot be measured solely in terms of federal budget savings. Any measure of success or failure must take into account the impact of reform on the quality, as well as the cost-effectiveness, of health care delivery in both the private and public sectors. Those who pay for health care coverage must have assurance that they are only liable for coverage that is necessary, and that they have appropriate control over their liabilities. Consumers must have assurance that they will receive adequate coverage for necessary services in a timely, efficient and effective manner. Providers must be assured that they will be able to operate in a professional and business climate that assures them that they can deliver proper care and receive appropriate financial return for their services.

With 15 percent of the economy at stake, we cannot afford to make major mistakes in evaluating, designing and implementing health care reform. We cannot afford grand experiments that risk spectacular failure. We need to take what we already know works, create strong incentives for its expansion, and grow into a reformed health care system to accomplish the President's laudable goals on a defined timetable.

A BASIS FOR FORGING CONSENSUS

As the health care system reform debate has unfolded, it has become increasingly clear that two dominant political realities set the limits for any possible consensus that can be reached. *First,* many Americans (both individual and corporate) do not want reform to result in more government bureaucracy or regulation—at either the state or federal level. *Second,* many Americans (both individual and corporate) are willing to pay their fair share to provide coverage to those who can't afford it—but only after they are convinced that appropriate cost containment mechanisms are in place and have been proven by experience to be effective, and that arbitrary or unfair cost shifting is eliminated. One may or may not like or agree with these two points, but they cannot be ignored.

Therefore, the only realistic model for needed changes in our health care system are the voluntary private employer-driven purchasing groups[2] that have sprung up

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[1] Copies of ERIC's *Policy Statement* can be obtained by Writing to The ERISA Industry Committee, 1400 L Street N.W., Suite 350, Washington DC 20005 or calling 202–789–1400.

[2] The term "voluntary private employer-driven" is used to describe purchasing groups that historically sprung from and continue to be energized by cooperative ventures within the business community, in contrast to purchasing groups that are organized and operated by government

around the country. ERIC's Policy Statement laid out the following framework for a consensus approach to reform based on this model:

First, significantly increase the role of private purchasing groups in the health care system by creating a federal tax preference or incentive for health care coverage obtained from such purchasing groups or from employers that act as their own purchasing group.[3] Purchasing groups (or employers acting as purchasing groups) should be expected to assume a number of the specific responsibilities, such as negotiating contracts and performance standards with providers, and collecting and disseminating data on quality and cost.

Second, impose basic "rules of fair conduct" governing the organization and operation of purchasing groups. As just one example, purchasing groups could not turn away individuals or employers that wish to participate on the basis of health risk. Because major medical markets are not limited by state boundaries, these "rules of fair conduct" would of necessity have to be exclusively federal and purchasing groups would have to be permitted to operate across state lines.

Third, we believe there must be effective cost containment throughout the private sector. There are two primary alternatives for cost containment in the private purchasing group model. One alternative consists of purchasing groups contracting on a capitated basis with competing integrated health care delivery systems (HMOs, managed care plans, etc.). The other alternative consists of private purchasing groups negotiating with providers a prospective budget, including fee schedules and volume limits. Depending on circumstances, one approach may be more effective than the other.

It is reasonable for federal tax policy to encourage or even require the use of these cost containment alternatives; it is not reasonable for the federal government to dictate to purchasers and providers in any given major medical market which approach is most appropriate for them. Because major medical markets. are not limited by state boundaries, these rules must be exclusively federal.

Fourth, government cost containment strategies have not contained aggregate health care costs because they have consistently created both an incentive for health care providers to increase the volume of services performed and an incentive for providers to shift costs to the private sector. The private cost containment strategy already described requires health care providers to assume financial risk for the failure to contain costs. Before reform can be considered complete, government programs such as Medicare and Medicaid must adequately compensate providers for the services they provide and require providers to assume financial risk for failure to contain costs.

It makes no sense for part of the market to work one way and another part to offer providers completely different incentives. We are confident that the private cost containment strategy described above will be effective. Moreover, we believe its effectiveness in containing aggregate health care system costs Would be greatly enhanced if Medicare, Medicaid and other government programs made the transition to the same cost containment techniques.

Fifth, if the quality and cost-effectiveness of health care is to improve over time, provider performance must be measured in a systematic manner. While absolutely essential to the long-term success of reform, techniques for measuring provider performance are still not yet fully developed, however. We should strongly encourage the use of such measurement systems; but for the time being, the government's role should be limited to providing guidance, fostering information exchange and monitoring development. Because the markets in which these measurement techniques will be applied are not limited by state boundaries, any rules relating to measuring provider performance would of necessity have to be exclusively federal.

MANDATES AND FINANCING

Up to this point in our statement, we have not addressed two topics of intense interest to the Committee—mandates and financing. We refrained from doing so to make a point. It is not possible to forge a broad consensus on mandates or financing in the abstract. Consensus must first be reached on how the rest of the system will look and operate before any kind of requirement to obtain or provide coverage and financing for those who cannot afford coverage should even be considered.

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entities. The term is not meant to suggest that individual consumers could not also participate in them.

[3] This could be accomplished, for example, by limiting the exclusion from personal income of the value of health benefits individuals receive from employers or government programs to coverage that is obtained through a purchasing group. Existing tax treatment of employer-provided coverage, including the full deductibility of employer-paid health benefit expenses, should be preserved.

Mandates:

ERIC has considered both individual and employer mandates at length. We have concluded that to achieve universal coverage some form of phased-in individual requirement is necessary to bring everyone into the health care system so that the system can operate efficiently and effectively. Thus, part of ERIC's proposed framework for reform, as articulated in our *1993 Policy Statement,* is a modified individual mandate, to be accompanied by income-based subsidies. We have also concluded that any effort to achieve universal coverage should not institutionalize the disproportionate share 'of health care costs currently borne by employers that voluntarily provide coverage to employees and dependents. Thus, our framework for reform also suggests that all employers make a meaningful contribution toward the costs of coverage.

Financing:

With respect to financing subsidies for persons unable to afford basic catastrophic coverage, ERIC believes that such financing should comply with the following criteria:

First, sources of revenue used to finance subsidies should be exclusively federal.

Second, sources of revenue used to finance subsidies should be explicit, not hidden or built into health care premiums or "sick taxes." There should be public accountability for subsidies and the amount of any revenues raised to pay for them.

Third, sources of revenue should be spread broadly. ERIC members are willing to share financing this social cost with their employees and the general public, so long as employers are not singled out to bear a disproportionate financial burden.

Fourth, as much as possible, sources of revenue should not add directly to employment costs.

Fifth, as much as possible, sources of revenue should be linked to incentives for improved quality and cost-effectiveness or other health policy goals.

ANALYSIS OF CURRENT REFORM PROPOSALS

In order assist the Committee in its discussions of specific health care reform proposals, we also have included in this statement an analysis of major bills introduced during the 103rd Congress.

1. Bills Reviewed:

ERIC's Board of Directors has reviewed the following proposals, which are analyzed in this statement:

- the Michel-Gingrich/Lott bills (H.R.3080/S.1533);
- the Cooper-Grandy and Breaux-Durenberger bills (H.R.3222 and S.1579, respectively);
- the Administration bill (H.R.3600/S.1757);
- the Nickles and Stearns bills (S.1743 and H.R.3698, respectively); and
- the Chafee and Thomas bills (S.1770 and H.R.3704, respectively).

ERIC continues to oppose single-payer health care reform proposals, whether they would establish a unified national single-payer system or individual state-by-state single-payer systems. ERIC believes that employers must retain control over any health benefits they help finance in order to manage their financial liabilities. In addition, ERIC believes that single-payer systems, in practice, are too inflexible and bureaucratic to fulfill the commitment to improve the quality and cost-effectiveness of health care delivery that is embodied in the health plans sponsored by major employers. Therefore, ERIC's analysis did not include the McDermott bill (H.R.1200) or other similar bills that have been introduced during the 103rd Congress.

2. General Assessment:

Each of the bills reviewed recognizes, either explicitly or implicitly, one or more of the principles and strategies for reform articulated in ERIC's *Policy Statement.* For example:

- The *Michel-Gingrich/Lott* bills recognize the need to address a number of specific factors contributing to the high cost of health care. The bills preempt state mandated benefits, anti-managed care and anti-utilization review laws, and include small-group insurance market reforms and medical malpractice reforms.
- The *Cooper-Grandy/Breaux-Durenberger* bills recognize the need to improve the quality and cost-effectiveness of health care delivery. They seek to create a marketplace where health care providers can be held accountable for their performance with respect to both quality and cost. Under the current health care 4 system, where health care is often financed on a piece-work, fee-for-service basis, there is insufficient accountability.

- The *Administration* bill recognizes that employers that currently provide voluntary coverage to employees, dependents and early retirees, or that voluntarily provide prescription drug coverage to Medicare-eligible retirees, bear a disproportionate share of national health care costs. It seeks to distribute the burden of financing health care more broadly across the economy and to achieve universal coverage.

The *Nickles/Stearns* bills recognize that the health care system can never operate at optimal efficiency unless all individuals participate in the system. They impose a significant tax penalty on taxpayers who do not obtain health insurance.

The *Chafee/Thomas* bills recognize the need for employers to maintain control over the health care they purchase on behalf of employees and dependents. They provide for voluntary private group purchasing arrangements, building on the important. contributions already being made by employer-led coalitions that have emerged in more than 90 locations around the country.

We believe the introduction of each bill has been an important contribution to the health care system reform debate Taken together, these five bills contain among them many of the necessary elements of successful health care system reform.

Each of the bills also has deficits, however, either in the manner in which certain key issues are addressed or in the failure to address certain key issues at all. When each bill was measured *individually* against the criteria set out in ERIC's *Policy Statement,* none of the alternative bills examined was deemed to adequately address the interests and concerns of major employers.

In general, each of the bills (in its present form) raises one or more of the following concerns:

- All of the bills lacked, in one or more areas, uniform federal rules governing the organization and operation of a reformed health care marketplace that are essential for major employers to offer and maintain their health benefit plans.
- All of the bills institutionalize, rather than reduce, cost shifting in one or more areas, including cost shifting from the public sector to the private sector. In addition, some of the bills fail to address cost shifting that results from the failure to achieve universal coverage.
- Employers would not be able to exert a sufficient degree of control (direct or indirect) over their financial liabilities, or the value (e.g., quality and cost-effectiveness) of the care they purchase, under several of the proposals.
- ERIC is not confident that adequate data and technology are currently available to implement the system of broad community rating, open enrollment and prospective risk adjustment called for under some of the bills without potentially causing unacceptable instability in the marketplace.
- Financing provisions under several of the bills fail to address adequately or realistically the costs created by the bills.

3. Bill-by-bill Assessment:

The following bill-by-bill assessments delineate the strengths and weaknesses of each bill in five areas that are essential to successful reform.

a. *Nationally uniform rules and standards.*

For major employers, which generally have employees geographically dispersed in multiple states, uniformity in the rules governing health reform is a very high priority. Moreover, health care is among the nation's biggest industries in interstate commerce. Major employers believe that to the degree the health care system is regulated at all, it must be subject to nationally uniform rules and standards to assure the quality and consistency of care throughout our health care system, and the common treatment of employees of the same employer.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich/Lott:* The bills increase uniformity in some areas relative to current law by preempting counterproductive state laws that interfere with the development of cost-effective health plans.
- *Cooper-Grandy/Breaux-Durenberger:* The bills increase uniformity in some areas relative to current law by preempting counterproductive state laws that interfere with the development of cost-effective health plans, but potentially erode uniformity in other respects. For example, granting states discretion in organizing health plan purchasing cooperatives and certifying accountable health plans would likely result in an undesirable degree of inconsistency from state to state.
- *Administration:* The bill erodes uniformity by providing excessive discretion to states in implementing regional alliance structures and in exercising the option to form single-payer systems. Financial incentives and administrative complexities are so heavily weighted against forming a corporate alliance that the ad-

vantage of limited federal preemption of state law afforded to corporate alliance sponsors is not enough to make forming a corporate alliance a viable option for most major employers. Thus, such employers effectively would be forced into state-run regional alliances—bureaucratic state government agencies with all their attendant problems and deficiencies.

- *Nickles/Stearns:* The bills erode uniformity by making all employer health plans, including self-insured plans, subject to state insurance laws. Model insurance reforms contemplated by the bills do not appear to guarantee state-to-state consistency.
- *Chafee/Thomas:* The bills erode uniformity for insured health plans by subjecting them to state regulation, but largely preserve uniformity for self-insured plans by subjecting them to federal regulation.

Recommendation: ERIC urges that any bill favorably reported by the Committee provide that federal law preempts any and all relevant state laws to preclude state discretion and ensure there will be national uniformity in all rules and standards that apply to how the health care system in general, and employer-sponsored health plans and purchasing groups in particular, will be organized and operated.

b. *Eliminating cost shifting.*

In the current health care system, ERIC member companies bear a disproportionate share of health care costs compared with other payers, particularly with respect to coverage of employed spouses who are not offered or who decline coverage from their own employers, coverage for pre-Medicare eligible retirees, and cost shifting resulting from uncompensated care (i.e., the uninsured) and undercompensated care (i.e., from Medicare and Medicaid). Cost shifting distorts the health care marketplace and undermines its efficient operation. Thus, the reduction, if not elimination, of such cost shifting is a high priority for ERIC member companies.

ERIC's insistence on the elimination of cost shifting does not mean major employers are unwilling to contribute their fair share toward the cost of providing appropriate income-related public subsidies for the purchase of health care. To ensure that there is public accountability for the amount and financing of such subsidies, however, at a minimum: (1) any such subsidies must be explicit (i.e., not merely built into the structure of health care premiums)', and (2) any taxes or other surcharges imposed on employers to help finance the cost of such income-related subsidies must be explicit (i.e., not merely built into the structure of health care premiums) and must be imposed on all payers.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich/Lott:* The bills do not address cost shifting.
- *Cooper-Grandy/Breaux-Durenberger:* The bills do not directly address cost shifting attributable to employed spouses or the expense of voluntary coverage for early retirees. In some cases, the bills appear to make cost shifting a permanent part of the structure of health care premiums. For example, by including current Medicaid beneficiaries in the same purchasing cooperative premium pool as private payers, the bills effectively shift part of the cost of financing coverage for such persons from general revenues to a per capita percent-of-premium tax on employment. The Medicare at-risk contract adjustment payment mechanism institutionalizes a cost shift from the federal government to "closed" as well as certain "open" accountable health plans. To the degree general Medicare cuts are used to finance the bills, cost shifting to private payers will worsen.
- *Administration:* The employer mandate reduces cost shifting currently resulting from employers that do not offer employees coverage to employers that offer family/dependent coverage, and partially reduces the cost to employers of providing pre-Medicare eligible retiree health coverage. On the other hand, by including current Medicaid beneficiaries in the same regional alliance premium pool as private payers, the bill effectively shifts part of the financing of such persons from general revenues to a per capita percent-of-premium tax on employment. By providing subsidies only to employers participating in regional alliances and by imposing percent-of-payroll taxes on employers forming corporate alliances, the bill institutionalizes cost shifts to corporate alliance sponsors, particularly those that have cost-effective plans. To the degree general Medicare cuts are used to finance the bill, cost shifting from that source will worsen.
- *Nickles/Stearns:* Tax incentives for individuals to purchase coverage may reduce cost shifting to some extent, but many forms of cost shifting remain.
- *Chafee/Thomas:* The individual mandate reduces cost shifting to some extent, but other forms of cost shifting remain. To the degree Medicare cuts are used to finance the bill, cost shifting will worsen.

Recommendation: ERIC urges that any bill reported favorably by the Committee ensure that every individual who does not receive health care coverage from either

(1) a government program, or (2) an employer by virtue of being an employee or a non-employed spouse or dependent, obtain such coverage from a federally sanctioned privately operated purchasing group. Any taxes or surcharges necessary to finance subsidies should be explicit (i.e., not built into the premium structure) and apply to all payers. In addition, all government health care programs should be required to purchase health care coverage using the same market competition mechanisms that private purchasers use and fund the full cost of such care.

c. *Employers' control over their financial liabilities.*

Because major employers have a long history of purchasing health care for large groups of employees, they have the greatest expertise and have achieved the greatest success in maximizing the value of the health care coverage purchased. Anyone who pays a substantial portion of the cost of health care coverage is entitled to and needs control over what and how it is purchased in order to control the payer's financial liabilities. Therefore, maintaining a strong employer influence over health care coverage purchasing decisions is a high priority for major employers.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich/Lott:* The bills do no apparent significant harm to the degree of employer control; they improve employer control to the extent the bills preempt state laws that interfere with employers' plan design decisions (i.e., preempts state mandated benefit laws, anti-managed care or anti-utilization review laws, etc.).
- *CooperGrandy/Breaux-Durenberger:* Although the bills limit all employers' control over plan design by specifying a uniform set of effective benefits, they otherwise largely preserve employer control over health coverage purchasing decisions (such as which health plans to contract with) for those employers that remain outside health plan purchasing cooperatives. Employers that are required to purchase care through such cooperatives retain some influence over the operation of the cooperative itself—by virtue of the fact that they are organized as nonprofit entities, rather than state agencies or quasi-private entities run by a board of political appointees as under the Administration bill—but they do not retain direct control over purchasing decisions.
- *Administration:* The bill erodes employer control over plan design and purchasing decisions. In addition to dictating a plan's scope of coverage, its cost-sharing features, and the mandatory fee-for-service option, the bill-subjects all employers to state discretion as to whether to establish a state-based single-payer system, and subjects employers participating in regional alliances (the vast majority of businesses) to state discretion as to whether to operate such alliances as state agencies or as quasi-private entities dominated by political appointees. Even employers forming corporate alliances are subjected to significant constraints, including requirements to offer three types of coverage even if an employer's experience has demonstrated that one or more types of coverage provide inferior value.
- *Nickles/Stearns:* Although employers are not directly constrained by federal law under these bills, employer control of both plan design and purchasing decisions would still be eroded by virtue of the fact that all employer plans would be subject to state insurance law. States historically have sought to undermine employer discretion through a variety of means: mandated benefit laws interfering with plan design and protecting health care provider special interests; anti-utilization review and anti-managed care laws; and taxing benefit plans. Although some of these avenues are foreclosed to states under the bills, others are not; states will continue to undermine employer discretion by every means made available to them under these bills.
- *Chafee/Thomas:* The bills' benefit package requirements place constraints on plan design, but employers generally retain full discretion with respect to purchasing decisions due to the voluntary nature of purchasing groups and the employer's role.

Recommendation: ERIC urges that any bill favorably reported by the Committee ensure that no employer is required to participate in a purchasing group that is operated as a government agency or that is run by political appointees. Further, to the degree that plan design is constrained at all—for example, by requiring that employers offer (but not necessarily contribute to the cost of) health care coverage, employers must still retain the flexibility to set the specific employer and employee cost sharing features of such coverage and to retain the option to offer actuarially equivalent benefits.

d. *Financial stability of the reformed marketplace.*

ERIC believes that health care reform must have as a primary goal changing the way health care is organized and delivered. A prerequisite for improved health care delivery is a more coherent and efficient health care marketplace.

Changes in the marketplace are dependent on available data and information technology, however. Forcing the marketplace to operate in a fundamentally different way than it does today and on the basis of inadequate data or immature information technologies, could result in market volatility great enough to cause serious financial harm (including insolvencies) to health plans or purchasing groups. Market-based reforms must not be abandoned because they are essential to successful reform generally; but they should be implemented cautiously, in stages where necessary, to minimize disruption.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich/Lott:* The bills do little to destabilize the marketplace, but also do little to directly improve the quality and cost-effectiveness of health care delivery.
- *Cooper-Grandy/Breaux-Durenberger:* Arguably, no one currently knows how to set age-banded, community-rated premiums in the context of both (1) unstable enrollment due to the elimination of barriers to free movement between health plans, and (2) prospective adjustments to payments made to accountable health plans based on the health risk posed by individual enrollees. Even if adequate data were currently available, which it is not, it is debatable that a single generalized risk adjustment formula can be developed that will work in health markets with disparate utilization patterns, demographic composition and other relevant differences. Moreover, if the financial pressure of an aggressive tax cap is added, as under these bills, the marketplace volatility that could result from near-to-immediate transition to the regulated market contemplated by these bills may produce an unmanageable number of accountable health plan and health plan purchasing cooperative insolvencies.
- *Administration:* The same concerns exist regarding the Administration bill as those expressed regarding the Cooper-Grandy/Breaux-Durenberger bills because at its core this bill is based on very similar community rating, open enrollment and risk adjustment requirements. The transition to the new principles is a little slower relative to Cooper-Grandy/Breaux-Durenberger, but the principles would be applied to a far greater proportion of employers and individuals. Market instability (i.e., health plan and regional alliance insolvencies) may be increased by the financial pressure added by the bill's requirement that a surcharge be imposed on health plans that exceed budget limits, which is another completely new risk that must be taken into account when determining what premium to bid.
- *Nickles/Stearns:* Though they would remove barriers to movement between competing health plans, there is little reason to expect that this alone would destabilize the marketplace as a whole. The bills are likely to do little to change health care delivery or improve its cost-effectiveness, however, because the bills encourage individual choice based on product differentiation (i.e., the scope of coverage and cost-sharing features) rather than the cost-effectiveness of health care delivery.
- *Chafee/Thomas:* The voluntary nature of purchasing groups and the voluntary adoption of prospective risk adjustment mechanisms, coupled with reliance on community rating within age bands rather than pure community rating, appear to mitigate the potential for instability in the operation of health care markets. The long-term effectiveness of this approach in improving the quality and cost-effectiveness of health care delivery depends on the emergence of specific effective strategies from the marketplace itself, a grass-roots approach that is likely to be more responsive to the needs of purchasers and providers, as well as less disruptive, than more rigid proposals.

Recommendation: ERIC urges that any bill that is favorably reported by the Committee strongly encourage group purchasing on a capitated basis, implement consensus insurance market reforms and provide for the voluntary adoption by employer-led private purchasing groups of specific strategies to improve market competition (such as prospective risk adjustment and related techniques) at an appropriate point in time, rather than prematurely imposing such strategies on the marketplace before they are fully developed.

e. *Credibility of financing provisions.*

Since health reform legislation inevitably has an impact on federal expenditures and the federal deficit, major employers view any financing provisions with well-founded skepticism. To be blunt, in the current budgetary environment, the benefits of various bills are often overstated and the costs are often understated or hidden.

Health reform is no exception. ERIC members are particularly concerned that underfinanced health reforms that are based on overly optimistic revenue estimates will ultimately impose far greater than expected liabilities on employers.

ERIC's assessment of the bills under consideration with respect to this issue is as follows:

- *Michel-Gingrich/Lott:* The bills do not require a significant of amount of financing relative to other bills.
- *Cooper-Grandy/Breaux-Durenberger:* Revenues to be raised from a cap on deductible employer health benefit expenses may be overstated since employer behavior will be hard to predict. For example, employers are likely to respond by seeking to shift/recharacterize their expenditures into other deductible expenses (e.g., wages). In addition, the cap will increase the cost of providing coverage for employers that voluntarily provide comprehensive benefits. Medicare savings may be partially offset to the degree such Medicare cuts cause cost shifting to the private sector, which in turn may result in increased deductible private employer expenditures.
- *Administration:* Financing is so complex that there is little likelihood that needed dollars can flow smoothly and efficiently from multiple sources to multiple destinations without shortfalls and windfalls along the way. The high probability that very few large employers will find forming a corporate alliance financially viable could substantially alter the expected mix of revenues to be generated by the percent-of-payroll tax on corporate alliance sponsors as compared to other revenue sources (including community-rate premiums). Medicare savings may be partially offset to the degree such Medicare cuts cause cost shifting to the private sector, which in turn may result in increased deductible private employer expenditures.
- *Nickles/Stearns:* The difficulty in predicting individual behavior in light of radical transformation of the tax treatment of health coverage (from income exclusion to tax credit) makes financing uncertain. Capping federal Medicaid payments could result in cost shifting, further distorting revenue estimates.
- *Chafee/Thomas:* Revenues to be raised from tax caps may be overstated due to the difficulty of predicting changes in employer and individual behavior caused by restructured tax incentives. Medicare and Medicaid savings may be partially offset by increased deductible private expenditures to the degree such cuts cause cost shifting to the private sector.

Recommendation: ERIC urges that any bill that is reported favorably by the Committee ensure that neither tax caps on the deductibility of employer health benefit expenses nor Medicare/Medicaid cuts are relied on as financing mechanisms. Further, any financing burden imposed on employers should not materially differ solely on the basis of an employer's decision to join or not join a purchasing group.

CONCLUSION

ERIC believes that successful health care system reform must respond to the following:

- Exclusive federal authority over a national health care policy;
- Improved accountability for the quality of health care and the outcome of treatment;
- Improved efficiency of health care markets by encouraging cost-effective group purchasing (through employer-led private purchasing coalitions) under uniform federal rules and standards;
- Equitable allocation of resources and financing burdens throughout the entire economy, including the elimination of cost shifting; and
- A transition strategy that minimizes disruption.

By this standard, none of the bills currently under consideration is likely to succeed without substantial revision.

ERIC supports market-based strategies for health care system reform that preserve the autonomy of employers and employer-sponsored health benefit plans, and have as their primary goal increased accountability for both the quality and cost-effectiveness of care. The members of ERIC represent a tremendous reservoir of experience and expertise regarding these issues. We look forward to the opportunity to work toward these goals with the Congress and the Administration generally, the Committee, and each of the individual bill sponsors.

PREPARED STATEMENT OF RON POLLACK

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify this morning on the question of universal access to health insurance. Families USA is a non-profit advocacy organization that has been consistently advocating for universal coverage on behalf of consumers.

I will not reiterate the reasons we so strongly support universal coverage. I am sure you all know the statistics and arguments. Rather, today, I would like to discuss the question of how universal coverage can be achieved.

There are really only three alternatives to achieving universal coverage. The first alternative uses a single-payer, government-financed methodology, similar to the Canadian system. The second and third alternatives, embodied in proposals co-sponsored by different members of this Committee, will be the subject of my testimony this morning.

One such approach—incorporated in President Clinton's Health Security Act—builds on our employer-based private health insurance system by requiring employers and workers to share the responsibility of paying for insurance premiums for workers and their families. The other approach is an individual-based insurance system similar to the way people obtain automobile insurance—an approach that is utilized in the bills offered by Representative Cooper and Senators Breaux and Durenberger (the Managed Competition Act) as well as Senator Chafee (the HEART Act), with the difference that the former does not mandate individual purchase of coverage while the latter bill does.

In theory, both employer-based and individual-based approaches to universal coverage can work. In practicality, however, we believe that the approach involving shared contributions by employers and employees offers the most realistic chance of achieving universal coverage. As my analysis this morning will demonstrate, this employer-based approach is likely to be much more affordable for the people and families needing health insurance coverage and is likely to be less costly to the government.

AFFORDABILITY FOR LOW-WAGE INDIVIDUALS AND FAMILIES

We evaluated the affordability of coverage for low-wage individuals and families with and without an employer contribution. Our results are in the following four charts. In evaluating the affordability with an employer contribution, we assumed that the maximum individual and family financial obligation would mirror the limits established in the Health Security Act. We also assumed that, like the Health Security Act, the employer contributions would be 80 percent and the employee contributions would be 20 percent. In evaluating the affordability without shared employer responsibility, we used two different subsidy schedules: a sliding scale subsidy for people whose incomes are between 100 percent and 200 percent of poverty (like the subsidy system established in the Cooper/Breaux-Durenberger bill) and a sliding scale subsidy for people whose incomes are from 100 percent to 240 percent of poverty (like the subsidy system established in the Chafee bill).

In chart 1, the overall premium for an individual remained constant at $2,100. This figure is the premium estimated by CBO for its analysis of the Health Security Act. The chart shows that, without an employer contribution, individuals whose incomes are between 150 and 250 percent of poverty (between $11,040 and $18,400 in annual incomes) would have to pay between 6.8 and 14.3 percent of their incomes for health insurance under a Cooper/Breaux-Durenberger subsidy system—up to more than seven weeks worth of pre-tax wages for premiums alone. This compares very unfavorably and unaffordably to a range of 2.3 to 3.8 percent of income for premiums if the employer makes contributions as proposed in the Health Security Act.

Also in chart 1 are the individual contributions that would be required under a Chafee subsidy system. For the same groups of individuals with incomes between $11,040 and $18,400, that subsidy system would result in individuals paying premiums between 6.8 and 11.4 percent of income—up to six weeks of pre-tax wages.

In chart 2 we applied the same sliding scale subsidies to a premium which represents the lowest cost plan (the method used in the Cooper/Breaux-Durenberger Managed Competition Act) and to a premium which represents the average of the lowest priced one-half of plans (the method used in Senator Chafee's HEART Act). Even with these adjustments, employees whose incomes are between 150 and 250 percent of poverty would have to pay amounts between 6.3 to 12.1 percent of their incomes for insurance premiums.

In chart 3 we examined the premium burden on families. We presumed a benefit package with a total premium of $5,565 for a family of four—the amount CBO estimated for the Health Security Act. We looked at the premium burden for families with incomes between 150 and 250 percent of poverty (annual incomes between $22,200 and $37,000).

Under the employer-based system established under President Clinton's Health Security Act, families earning between $22,200 and $37,000 would pay no more than 3.9 percent of their incomes on premiums. By contrast, under a Cooper/Breaux-Durenberger subsidy approach, such families would pay between 12.5 and 18.8 percent of their incomes—up to almost ten weeks in pre-tax wages for premiums alone. Under Senator Chafee's subsidy approach, such families would pay between 9.0 and 15.0 percent of their incomes—up to almost eight weeks in pre-tax wages.

In chart 4 we also examined the premium burden on families. In chart 4, however, we applied the Cooper/Breaux-Durenberger subsidy system to a premium representing the lowest cost plan (the method used in the Cooper/Breaux-Durenberger Managed Competition Act) and to a premium representing the average of the lowest price one-half of plans (the method used in Senator Chafee's HEART Act). Even with these adjustments, employees whose incomes are between 150 and 250 percent of poverty would have to pay amounts between 10.7 and 16.0 percent of their incomes for insurance premiums.

The premiums required of individuals and families under the individual-based financing systems established under the Cooper/Breaux-Durenberger and Chafee bills constitute unrealistic and unaffordable burdens. They simply won't achieve universal coverage for these lower-wage workers because the premiums are far too high to be affordable. President Clinton's Health Security Act, based on an approach of shared responsibility among employers and workers, does enable workers to afford their premium responsibilities. This is why we strongly support an employer-based financing approach.

We know that this Committee may consider a compromise that incorporates an individual-based financing approach for some portion of the working population. In such a compromise the government cost will go up because subsidies must be much more generous for lower-income people and families so that the premiums are realistically affordable.

It is noteworthy to point out that these unaffordable premium burdens in the Cooper/Breaux-Durenberger and Chafee plans are not the only financing burdens that need to be shouldered by families. Additionally, these families will be required to pay out-of-pocket costs for deductibles and co-payments as well as the entire costs for uncovered services. Clearly, these individual-based financing proposals are unrealistic plans for achieving anything approximating universal coverage.

In one respect, however, the Clinton plan also needs improvement. Under the Health Security Act, individuals and families with earnings below the poverty line would be required to pay 3.0 percent of their incomes as a premium. Other bills, like Cooper/Breaux-Durenberger and Chafee, would require no premiums for those below the poverty line. We believe that people with incomes below the meager poverty line ($7,360 for individuals and $14,800 for a family of four) do not have the capability to pay out-of-pocket for premiums, deductibles or co-insurance, and no health reform plan should require them to do so.

GOVERNMENT COST OF EMPLOYER-BASED VS. INDIVIDUAL-BASED FINANCING

We evaluated the comparative financial burden to government of an employer-based finance system versus an individual- and family-based finance system. Since there appears to be little sentiment in Congress to raise significant new revenues, this analysis helps to gain a perspective about the political difficulties of achieving similar cost protections for lower-wage workers and their families under the two financing systems.

We did not attempt to calculate the total federal costs of an employer-based finance system versus an individual-based system. We do not have the capability of producing such data, and this is precisely the type of data that CBO should provide for the Committee. But the analysis we did perform suggests that—if the same type of out-of-pocket protections are to be provided for individuals and families under the two systems—the individual-based financing system is likely to be much more costly. As such, it is far more likely that Congress will be tempted to provide less income protection for families, thereby risking the unaffordability of coverage—and, hence, may fail to meet the crucial goal of universal coverage.

In the examples arrayed in tables 5 and 6, we analyzed the government's costs of providing similar premium caps for individuals and families under the two financing systems. For illustrative purposes, we used the premium cap protections established under President Clinton's Health Security Act. That legislation limits the premium burden for individuals and families at 3.9 percent of income. For the employer-based finance system, we assumed an employer premium contribution of 80 percent. We also factored in a limitation in the premiums to be paid by employers, such that employers would never pay premiums in excess of 7.9 percent of payroll—

also as envisioned by the Health Security Act. We believe this analysis would yield comparable results even if different limits on premiums were used.

In table 5, we offer two examples: (1) an individual with $10,000 in income who is a half-time worker, and (2) an individual with $15,000 in income who is a full-time worker. (In both sets of examples, we presumed that the total premium costs are $2,100—CBO's estimate of the premium costs under the Health Security Act.) For the former, the government's subsidy burden under an employer-based finance system would be $1,315—a $445 subsidy for the employer and an $870 subsidy for the worker. The government's subsidy burden under an individual-based finance system would be $1,710, or $395 more. In the latter example, the government's subsidy burden under an employer-based finance system would be $495 compared to a subsidy burden of $1,515 under an individual-based finance system—a difference of $1,020.

Similarly, in table 6, we examined two examples of four-person families that have a full-time worker: (1) where the breadwinner earns $20,000, and (2) where the breadwinner earns $30,000. Again, under both examples, the government's subsidy burden is considerably greater under the individual-based finance system.

In the first family example, the government's subsidy burden under the employer-based finance system would be $3,205—a $2,872 subsidy for the employer and a $333 subsidy for the family. under the individual-based finance system, the government's subsidy burden would be $4,785, or $1,580 more. In the second example, the government's subsidy burden under an employer-based system would be $2,082 compared to a subsidy burden of $4,395—or $2,313 larger—under an individual-based finance system.

As these examples illustrate, the subsidy burden for government is considerably greater under an individual-based system. For individuals and families, therefore, there is a greater risk under an individual-based finance system that the subsidies Congress would establish would be inadequate to ensure affordable insurance coverage. Under the individual-based finance system, Congress must either come up with greater revenues or pare back premium subsidies—thereby, as in the Cooper/Breaux-Durenberger and Chafee bills, providing insufficient subsidies to make premiums affordable for lower-wage working families.

CONCLUSION

Universal health insurance coverage is a goal we can and must reach. In attempting to do so, it is crucial that Congress gives careful scrutiny to the premium burden being placed on all parties involved—not least of all the premium burdens of workers and their families. The cap on premium and other out-of-pocket costs must be realistically established so that insurance is truly affordable. We believe that, given the political difficulties of raising government revenues to provide adequate subsidization of families' premium burdens, an employer-based finance system is the most realistic method of achieving universal coverage.

TABLE 1

Affordability of Health Insurance for Low-Wage Individuals

	Individual's Premium[a]	Percent of Income
Annual Income of $7,360 (100% of poverty)		
Health Security Act	$223	3.0%
Individual Subsidies Like Cooper-Breaux[b]	$0	0%
Individual Subsidies Like Chafee[c]	$0	0%
Annual Income of $11,040 (150% of poverty)		
Health Security Act	$420	3.8%
Individual Subsidies Like Cooper-Breaux[b]	$1,050	9.5%
Individual Subsidies Like Chafee[c]	$750	6.8%
Annual Income of $14,720 (200% of poverty)		
Health Security Act	$420	2.9%
Individual Subsidies Like Cooper-Breaux[b]	$2,100	14.3%
Individual Subsidies Like Chafee[c]	$1,500	10.2%
Annual Income of $18,400 (250% of poverty)		
Health Security Act	$420	2.3%
Individual Subsidies Like Cooper-Breaux[b]	$2,100	11.4%
Individual Subsidies Like Chafee[c]	$2,100	11.4%

[a] This analysis uses premium estimates calculated by the Congressional Budget Office (CBO) for its analysis of the Health Security Act. CBO estimated that the average annual premium for an individual would be $2,100 in 1994.

[b] This Act would provide full subsidies up to 100 percent of poverty and sliding scale subsidies up to 200 percent of poverty.

[c] This Act would provide full subsidies up to 100 percent of poverty and sliding scale subsidies up to 240 percent of poverty.

TABLE 2

Affordability of Health Insurance for Low-Wage Individuals

	Individual's Premium	Percent of Income
Annual Income of $7,360 (100% of poverty)		
Health Security Act[a]	$223	3.0%
Individual Subsidies Like Cooper-Breaux[b]	$0	0%
Individual Subsidies Like Chafee[c]	$0	0%
Annual Income of $11,040 (150% of poverty)		
Health Security Act[a]	$450	3.8%
Individual Subsidies Like Cooper-Breaux[b]	$893	8.1%
Individual Subsidies Like Chafee[c]	$694	6.3%
Annual Income of $14,720 (200% of poverty)		
Health Security Act[a]	$420	2.9%
Individual Subsidies Like Cooper-Breaux[b]	$1,785	12.1%
Individual Subsidies Like Chafee[c]	$1,388	9.4%
Annual Income of $18,400 (250% of poverty)		
Health Security Act[a]	$420	2.3%
Individual Subsidies Like Cooper-Breaux[b]	$1,785	9.7%
Individual Subsidies Like Chafee[c]	$1,943	10.6%

[a] The Health Security Act would provide premium assistance for average-priced plans. The Congressional Budget Office (CBO) estimated that the average annual premium for an individual would be $2,100 in 1994.

[b] The Managed Competition Act would provide premium assistance for the lowest-priced plan. CBO has estimated that the lowest-priced plan would have a premium 15% below the average. Based upon CBO premium estimates, this premium would be $1,785. This Act would provide full subsidies up to 100 percent of poverty and sliding scale subsidies up to 200 percent of poverty.

[c] The HEART Act would provide premium assistance for the average of the lowest-priced one-half of plans. Based upon CBO premium estimates, this premium would be about $1,943 (the average of $2,100 and $1,785). This Act would provide full subsidies up to 100 percent of poverty and sliding scale subsidies up to 240 percent of poverty.

TABLE 3

Affordability of Health Insurance for Low-Wage Families[a]

	Family's Premium[b]	Percent of Income
Annual Income of $14,800 (100% of poverty)		
Health Security Act	$442	3.0%
Families Subsidies Like Cooper-Breaux[c]	$0	0%
Families Subsidies Like Chafee[d]	$0	0%
Annual Income of $22,200 (150% of poverty)		
Health Security Act	$866	3.9%
Families Subsidies Like Cooper-Breaux[c]	$2,783	12.5%
Families Subsidies Like Chafee[d]	$1,988	9.0%
Annual Income of $29,600 (200% of poverty)		
Health Security Act	$1,113	3.8%
Families Subsidies Like Cooper-Breaux[c]	$5,565	18.8%
Families Subsidies Like Chafee[d]	$3,975	13.4%
Annual Income of $37,000 (250% of poverty)		
Health Security Act	$1,113	3.0%
Families Subsidies Like Cooper-Breaux[c]	$5,565	15.0%
Families Subsidies Like Chafee[d]	$5,565	15.0%

[a] This analysis is a based on a family of four—two parents with two children.

[b] This analysis uses premium estimates calculated by the Congressional Budget Office (CBO) in its analysis of the Health Security Act. CBO estimated that the average annual premium for a two-parent family would be $5,565.

[c] This Act would provide full subsidies up to 100 percent of poverty and sliding scale subsidies up to 200 percent of poverty.

[d] This Act would provide full subsidies up to 100 percent of poverty and sliding scale subsidies up to 240 percent of poverty.

TABLE 4

Affordability of Health Insurance for Low-Wage Families[a]

	Family's Premium	Percent of Income
Annual Income of $14,800 (100% of poverty)		
Health Security Act[b]	$442	3.0%
Families Subsidies Like Cooper-Breaux[c]	$0	0%
Families Subsidies Like Chafee[d]	$0	0%
Annual Income of $22,200 (150% of poverty)		
Health Security Act[b]	$866	3.9%
Families Subsidies Like Cooper-Breaux[c]	$2,365	10.7%
Families Subsidies Like Chafee[d]	$1,839	8.3%
Annual Income of $29,600 (200% of poverty)		
Health Security Act[b]	$1,113	3.8%
Families Subsidies Like Cooper-Breaux[c]	$4,730	16.0%
Families Subsidies Like Chafee[d]	$3,677	12.4%
Annual Income of $37,000 (250% of poverty)		
Health Security Act[b]	$1,113	3.0%
Families Subsidies Like Cooper-Breaux[c]	$4,730	12.8%
Families Subsidies Like Chafee[d]	$5,148	13.9%

[a] This analysis is a based on a family of four—two parents with two children.

[b] The Health Security Act would provide premium assistance for average-priced plans. The Congressional Budget Office (CBO) estimated that the average annual premium for a two-parent family would be $5,565 in 1994.

[c] The Managed Competition Act would provide premium assistance for the lowest-priced plan. CBO has estimated that the lowest-priced plan would have a premium 15% below the average. Based upon CBO premium estimates, this premium would be $4,730. This Act would provide full subsidies up to 100 percent of poverty and sliding scale subsidies up to 200 percent of poverty.

[d] The HEART Act would provide premium assistance for the average of the lowest-priced one-half of plans. Based upon CBO premium estimates, this premium would be about $5,148 (the average of $5,565 and $4,730). This Act would provide full subsidies up to 100 percent of poverty and sliding scale subsidies up to 240 percent of poverty.

TABLE 5

GOVERNMENT COST OF EMPLOYER- VS. INDIVIDUAL-BASED SUBSIDIES

Individual with $10,000 Income, Half-time Worker

	Total Premium[a]	Maximum Premium Contribution[b]	Government Subsidy
Employer-Based Subsidies[c]			
Employer Portion	$840	$395	$445
Individual Portion	$1,260	$390	$870
Total	$2,100		$1,315
Individual-Based Subsidies[d]			
Individual Portion	$2,100	$390	$1,710

Individual with $15,000 Income, Full-time Worker

	Total Premium[a]	Maximum Premium Contribution[b]	Government Subsidy
Employer-Based Subsidies[c]			
Employer Portion	$1,680	$1,185	$495
Individual Portion	$420	$585	
Total	$2,100		$495
Individual-Based Subsidies[d]			
Individual Portion	$2,100	$585	$1,515

[a] Based on the premiums estimated by the Congressional Budget Office for the Health Security Act, $2,100 annually for individually coverage.
[b] Assumes individuals pay no more than 3.9% of their income for premiums and businesses pay no more than 7.9% of the worker's salary.
[c] With an employer mandate, employers pay 80% of the premium for a worker up to 7.9% of the worker's salary and individuals pay 20% of the premium up to 3.9% of income.
[d] With an individual mandate, individuals pay 3.9% of their income for their premium.

TABLE 6

GOVERNMENT COST OF EMPLOYER– VS. INDIVIDUAL–BASED SUBSIDIES

Family with $20,000 Income, Full-time Worker

	Total Premium[a]	Maximum Premium Contribution[b]	Government Subsidy
Employer-Based Subsidies[c]			
Employer Portion	$4,452	$1,580	$2,872
Family Portion	$1,113	$780	$333
Total	$5,565		$3,205
Individual-Based Subsidies[d]			
Family Portion	$5,565	$780	$4,785

Family with $30,000 Income, Full-time Worker

	Total Premium[a]	Maximum Premium Contribution[b]	Government Subsidy
Employer-Based Subsidies[c]			
Employer Portion	$4,452	$2,370	$2,082
Family Portion	$1,113	$1,170	
Total	$5,565		$2,082
Individual-Based Subsidies[d]			
Family Portion	$5,565	$1,170	$4,395

[a] Based on the premiums estimated by the Congressional Budget Office for the Health Security Act, $5,565 annually for family coverage.
[b] Assumes families pay no more than 3.9 % of their income for premiums and businesses pay no more that 7.9% of the worker's salary.
[c] With a employer mandate, employers pay 80% of the premium for a worker and their family up to 7.9% of the worker's salary and families pay 20% of the premium up to 3.9% of income.
[d] With an individual mandate, families pay 3.9% of their income for their premium.

PREPARED STATEMENT OF JOHN J. SWEENEY

Mr. Chairman, members of the committee, I am John J. Sweeney, International President of the Service Employees International Union, Vice President of the AFL–CIO and Chairman of the Health Care Committee of the Executive Council of the AFL–CIO. Thank you for this opportunity to testify on behalf of the AFL–CIO on one of the most critical issues facing our nation today. After 50 years of struggle, we are on the verge of bringing much needed reform to our nation's health care system. We applaud the President and the Congress for tackling this issue, and I am pleased to be invited to present our views to the committee.

Affiliated unions of the AFL–CIO represent over 16 million working men and women across the United States. They work in thousands of different jobs in dozens of industries. They build our homes, make our cars, bake our bread, tend our sick, and deliver our public services.

Our members don't need charts and graphs or expert pronouncements to understand that there is a crisis in our health care system. They have fought hard to hold on to their health insurance, often foregoing wage increases and improvements in other benefits to maintain coverage for themselves and their families. They have faced greater out-of-pocket costs and declining choices as employers have tried to restrict where and when they can see their family doctors.

While disagreements over health care issues have made collective bargaining more contentious than it otherwise would have been, labor and management have also worked together to pioneer new cost containment strategies such as utilization review and managed care. While these measures showed some short-term success, they were unable to blunt the long-term rise in costs. Only system-wide reform can provide the relief that workers and their employers need.

I am here today to present the views of the AFL–CIO on employer responsibilities in regard to health care coverage. We believe that, short of a tax-financed social insurance system, an employer mandate is the only feasible way to secure health coverage for all Americans.

There are three issues I want to address this morning. I want to restate why we believe that universal coverage must be at the center of any healthcare reform effort. I then want to discuss the advantages of using an employer mandate to achieve universal coverage. Finally, I want to point out some of the real benefits that the Health Security Act provides to employers, especially the majority who are already providing health insurance for their workers.

UNIVERSAL COVERAGE

It should be a source of shame to us that in the richest nation on earth there are 39 million people without any form of health insurance whatsoever. As many as 50 million more are underinsured and often do not discover the crucial gaps in their health insurance until it is too late. In addition to the high cost of health insurance, many individuals and families are denied coverage because their employer does not provide it or because of pre-existing conditions that the insurance company refuses to cover.

Over the past ten years, we have witnessed the reversal of the long-term trend of increasing amounts of health insurance coverage for working Americans. Over the past few years, the erosion of coverage has accelerated.

Not only are we failing to expand coverage. We are now steadily losing coverage among previously insured workers. And even those who have been traditionally well-insured are anxious about what will happen to their coverage. One out of every four Americans will lose their insurance at some point in the next two years and a New York Times poll published earlier this week showed that 45 percent of Americans fear they will lose their coverage sometime in the next five years.

Union members across the country report that employers have been trying to scale back their health insurance coverage and/or imposing greater restrictions on its use.

The AFL–CIO has long been on record in support of universal health insurance coverage. We stand squarely behind the principle that health care is the right of all people—a social good of such far-reaching importance that it should be assured by society. No one should be denied coverage because of their income, health or employment status.

The first argument for universal coverage is a moral one, a perspective that is often forgotten during the national debate. I think that the Catholic Bishops of the United States put it well when they wrote last summer that "health care is more than a commodity; it is a basic *human right,* an essential safeguard of human life and dignity." Access to care when we are sick should not depend on whether we are young or old, employed or unemployed, rich or poor.

There are also, however, overwhelming economic arguments in favor of universal coverage. The existence of a large pool of uninsured individuals drives up health care costs for the rest of the population. It is well known that uninsured individuals are more likely to postpone needed primary and preventive care and wait until their condition becomes serious enough to warrant a trip to the emergency room. This is the most costly form of care imaginable.

The growing number of uninsured is also a particular burden to our nation's public health system, particularly public hospitals. Members of my own union, the Service Employees International Union, work in hospital emergency rooms across the country where the vast majority of patients they see are not there for emergencies. They are there because they are uninsured and this is the only way they can get to see a doctor. The financial burden of uncompensated care is leading to friction at the bargaining table, as public hospital administrators seek layoffs, wage cuts, and the substitution of lower skilled workers for more highly skilled ones. Our members would much rather be discussing ways to improve the quality of care that their patients receive.

WHY ALL EMPLOYERS SHOULD CONTRIBUTE

If we can agree that universal coverage is the objective, the question becomes how to provide it. The system that we have right now can be characterized as a voluntary, employer-based system. That system is under tremendous stress because of rapidly rising health care costs. With every passing day, the incentives grow for companies to drop their health benefits. Small employers are being driven out of the system most rapidly—in 1992 alone the percentage of small Fran (25 employees and under) employees without health insurance grew by two percentage points—from 29 to 31 percent.

When workers lose their coverage, they don't stop consuming health care services, but they do consume them differently. Because they lack coverage, the uninsured tend to postpone needed primary and preventive care. When their conditions become serious enough, they go to the emergency room because they know that, in most cases, they will not be turned away.

Who pays for this care? Employers and workers do. Right now, every bill we pay and every premium payment we make contains a hidden surcharge that goes to cover the more than $25 billion a year in care that hospitals provide to the uninsured.

Many employers who are currently providing insurance are paying more than their fair share because they are providing coverage for the working spouses of their employees. In essence, they are subsidizing their competition. A 1991 National Association of Manufacturers study found that the cost of providing coverage to working dependents increases costs for firms providing insurance by 20 percent.

The growing disparity in labor costs between firms that do provide health insurance and those that don't is generating serious distortions in the labor market. The dramatic increase in the number of part-time and contingent employees, which constitute half of all new jobs created during the past year, is being driven in large part by the desire of employers to avoid the cost of health care.

A number of our employers are finding it harder to compete with firms that do not provide health insurance. SEIU Local 750, for example, which represents building service workers in Orlando, Florida reports that a union contractors lost a cleaning contract with Delta Airlines that it had held for over eight years to a non-union contractor. The non-union contractor did not provide health insurance for its workers, and thus was able to underbid the unionized contractor.

The loss of the contract added insult to injury, because the members of Local 750 have worked hard to keep costs under control. For over a decade, workers have been offered a choice of 3 HMOs and 1 PPO. In order to keep costs down, however, they have been forced to change vendors every two years. These changes often result in a disruption of established relationships with physicians and other providers.

In the public sector, proponents of privatization have argued that public services can be delivered more cheaply by private sector contractors. In most cases, however, we have found that the only reason that these contractors are able to provide the same services at lower cost is that they do not provide health insurance for their workers.

The experience of displaced workers demonstrates that high employer costs for health benefits are contributing to the destruction of jobs with health insurance on a massive scale. According to the Bureau of Labor Statistics, of 4.2 million workers who had been displaced from jobs with insurance during the previous five years, only 2.2 million had been re-employed with health insurance as of January 1992. The rest were working without insurance, were unemployed or had left the labor

force. While many of these had coverage. the source was no longer their own employer.

For these reasons, the AFL–CIO strongly supports requiring all employers to contribute to the cost of their workers' health insurance. The strength of this approach is that it builds on the existing system. Nearly two-thirds of the non-elderly have employment-based coverage. Among the 39 million Americans who lack insurance, 85 percent belong to families that include an employed adult. A system that requires all employers to contribute will reach the vast majority of the uninsured.

Some who support requiring all employers to contribute believe that employers should only be required to provide a minimal, catastrophic benefit package or to only contribute 50 percent or less of the premium. The AFL–CIO takes issue with both of these positions.

With respect to the benefit package, everything we've learned about the health care system over the past decade suggests that providing people with only catastrophic benefits leads to underutilization of primary care. This leads to higher costs in the long run. Denying coverage for prescription drugs drives up costs in the same way because it encourages patients to favor more invasive (and expensive) treatments simply because they are covered. Do we really think that denying people coverage for substance abuse treatment saves the health care system money?. Once you start to think about it and work it through you are led to the inevitable conclusion that a comprehensive benefits package is the only kind that makes sense.

The AFL–CIO is also critical of the idea that employers should pay less than 80 percent of the premium. When we talk about employers paying less, what we're really talking about is making workers pay more. Some of our members are already paying 30 percent, and even 40 percent of their premiums and it's killing them. If you assume an average family premium of around $5,000, you're talking about hitting some middle-income families with a bill of $2,500.

WHY AN INDIVIDUAL MANDATE WON'T WORK

Some critics of the Health Security Act have argued that an individual mandate would be fairer and more efficient than an employer mandate. We have to disagree. Our concerns about an individual mandate focus on its fairness and its feasibility.

An individual mandate would have a significantly negative impact on low and moderate income individuals. The uninsured tend to have low incomes—88 percent were in families with adjusted gross incomes below $20,000. They simply cannot afford the cost of insurance plans costing several thousand dollars a year. The only way to make it possible for such individuals to afford insurance would be to provide substantial government subsidies, financed through significant new taxes.

An individual mandate also would be extremely difficult to enforce. A large number of low-income individuals do not file federal income tax returns or come in contact with federal regulatory agencies. The federal government would have to spend additional millions of dollars tracking down and prosecuting those who failed to purchase insurance.

It is also likely that many employers, especially employers of low-wage workers. would drop their coverage entirely in response to an individual mandate. According to the Employee Benefits Research Institute, the number of non-elderly Americans receiving health insurance through their employer fell by 2.2 million between 1988 and 1992. The pressure on firms to drop insurance will only increase in the future as more and more firms seek a competitive advantage by eliminating these important benefits. For this reason, an individual mandate would merely perpetuate the problem of employers who are not providing insurance shifting costs to those who do.

It is important to realize that none of the individual mandate proposals contain any form of serious cost control. Over the last decade families have faced rapidly rising premiums and increased levels of cost-sharing. To impose a health insurance mandate on middle-class families without any assurance that costs will not continue to spiral out of control is simply unfair.

WHY INSURANCE MARKET REFORM ISN'T SUFFICIENT

Another alternative favored by those who oppose requiring all employers to contribute is insurance market reforms. Some of the reforms that have been suggested include regulating the insurance market to make it easier for those without insurance to obtain it. These provisions, which are common to most health care reform bills, include prohibiting pre-existing condition exclusions and requiring insurers to community-rate instead of experience-rate.

Without a requirement that all employers contribute to the cost of their employees' health insurance, these reforms would significantly increase the risk profile of

most insurance pools. Insurance companies would have to raise their rates to cover the additional cost. This could lead businesses who are currently providing insurance to drop coverage, potentially creating a vicious circle that would ultimately undermine the entire health insurance market.

Requiring all employers to contribute, by contrast, would bring millions of younger. relatively healthier workers into the health insurance system, which would greatly reduce the overall level of risk in a community-rated system. This brings down costs for insurance companies, businesses and consumers.

While insurance reforms are clearly necessary to eliminate discrimination in the health insurance market, they must be implemented in tandem with cost control provisions that ease the burden on those businesses and consumers whose costs will go up under reform. To do otherwise creates the potential for a political backlash that could undermine the entire health care reform effort.

Another proposal of those who favor reform of the small group market are small. voluntary purchasing cooperatives that would offer group purchasing power to small employers. No matter how the purchasing cooperatives are structured, they are unlikely to work without an employer mandate. A purely voluntary approach almost certainly will lead to adverse selection among workers in the cooperative. Those employees who are more likely to be sick will purchase coverage, while those are relatively healthy may go without coverage. This, in turn, will raise costs for those who do choose to purchase coverage. The result could be a vicious cycle that could well destroy the purchasing cooperative as a meaningful entity. If small employers are unable to realize lower premiums as a result of their membership, they are no more likely to purchase coverage for their workers than they are now.

With the help of the Robert Wood Johnson foundation, a number of states have experimented with purchasing cooperatives for small business that operate on a voluntary basis. While some small employers did obtain coverage through these arrangements, even the most successful project only enrolled 17 percent of employers who previously had not offered insurance. The Arizona Health Care Group, one of the longest running projects, only succeeded in enrolling 939 small firms, for a total of 3,093 covered lives, during the First three and half years of its existence. Similar experiments in other states proved similarly disappointing.

A pilot project in New York where the state offered to pay 50 percent of the premium to specific HMOs for Firms with 20 or fewer employees without insurance was similarly unsuccessful. A study of the project's effect after one year determined that the subsidized insurance accounted for an increase of only 0.6 to 3.5 percentage points in the proportion of small firms providing insurance. More than one-quarter of the small Firm owners surveyed stated that they had little or no interest in purchasing insurance at any price either because their employees already had coverage through a spouse's employer or because the available plans did not interest them.

The results of the American Hospital Association's 1991 survey of chief executives of voluntary purchasing cooperatives were also discouraging. Less than half of those surveyed agreed that the cooperative had made a difference in controlling health care costs in their community.

BENEFITS FOR EMPLOYERS UNDER THE HEALTH SECURITY ACT

Some employer associations have complained bitterly about the cost of an employer mandate, while ignoring the significant benefits that many businesses will receive as a result of the President's plan. Aside from cost control measures which will benefit both employers and workers, the plan calls for a cap on employer premium contributions of 7.9 percent of payroll. Many businesses who provide health insurance to their employees currently pay more and stand to gain significantly under the plan.

The President's proposal also calls for a lifting of the heavy burden on businesses competing in the global marketplace by subsidizing the crippling costs of early retiree health care coverage. Most of our major international competitors spread the cost of retiree coverage across their entire population. We must follow the same path if our products are to be competitively priced and our domestic productivity is to be enhanced.

Some members of Congress are suggesting that the Clinton plan is financing reform on the backs of small businesses. The truth is that the majority of small businesses already provide health care coverage to their workers and are among the biggest winners under the Clinton plan. The Health Security Act takes three strong steps to address the cost burdens of small businesses.

First, the Health Security Act gives small businesses the power of numbers. If we pool small businesses and the self-employed together and allow them to buy private coverage through purchasing groups, they'll have the market Power big businesses

have to get better prices and guarantee employees a choice of good plans. Second, insurers will have to charge a small business employee the same price as their other customers. Finally, under the Health Security Act, small businesses would have their premium contributions capped according to their ability to pay. The smallest businesses employing predominantly low-wage workers would pay no more than 3.5 percent of payroll. Valid questions have been raised about the cost and equity issues involved in such a significant subsidy for small business, but we have heard no convincing argument against small business subsidies per se.

It should be remembered, however, that this is not solely a big company/small company issue. Many of the workers who are now uncovered work for the largest companies. EBRI estimates that one-quarter of all uncovered workers (4.4 million) are in firms with 1,000 or more employees. This is roughly equal to the number of uninsured (4.6 million) who work in the smallest firms (under 10 employees).

In fact, a large proportion of small businesses have as much at stake in universal coverage as large employers. More than three-quarters of small firms (except those with fewer than 10 employees) now provide health benefits to their workers. These firms pay for their own workers, plus the uninsured, and would benefit significantly from having their competition paying their fair share.

TRUTH AND FICTION ABOUT JOB LOSS

No issue has been more distorted by opponents of the Health Security Act than the plan's impact on jobs. Two commonly cited studies, by the Employment Policies Institute and the CONSAD Research Corporation, make several fundamental errors in characterizing the Health Security Act. They completely exclude from their analysis the discounts to small and low-wage businesses that the plan provides; they use a benefit package that is far more expensive than that included in the Act; and their assumptions about how firms change their employment in response to cost changes is at least three to six times higher th1m most conventional estimates.

Real world evidence suggests that mandates do not have a major impact on the number of jobs available. Hawaii imposed an employer health insurance mandate in 1974. Since then, private non-farm employment in Hawaii increased by 90 percent, compared to 54 percent in the United States as a whole. Employment in retail and wholesale trade, which in theory would have been especially vulnerable to the mandate because of the large number of minimum wage workers, actually grew faster in Hawaii than in the United States as a whole.

The effect of any mandatory health insurance contribution will be greatest among workers who are paid the minimum wage. This is because the statutory wage minimum precludes any offsetting wage reductions in response to the mandate. Hence, most observers agree that, with respect to low-wage workers, mandatory employer health insurance is tantamount to an increase in the minimum wage.

Fortunately, there have been a number of recent studies about the impact of increasing the minimum wage. Professor David Card of Princeton University examined what happened when California increased its minimum wage in July 1988 by 27 percent. At the time, 11 percent of the state's workers earned less than the new minimum of $4.25, including 50 percent of teenagers. Professor Card compared California's employment experience with states where no increase occurred. The analysis showed that while the earnings of low-wage workers did increase, there was no employment effect, even among teenagers. Furthermore, Professor Card found no relative shrinkage of employment in retail trade, the sector most dependent on minimum-wage labor.[1]

In another study, Professor Card compared the experiences of low and high wage states which have different proportions of workers affected by changes in the federal minimum. Again, no negative impact on teenage employment could be discerned.[2]

Lawrence Katz of Harvard University and Alan Krueger of Princeton University collaborated on a study of fast-food outlets in Texas. They, too, found no negative employment effects as the federal minimum wage rose by 27 percent between 1990 and 1991.[3]

As the graph makes clear, for the smallest firms (less than 25 employees) employing minimum wage workers, the cost imposed by the Health Security Act will be no more than 15 cents per hour, significantly lower than the 90 cent per hour in-

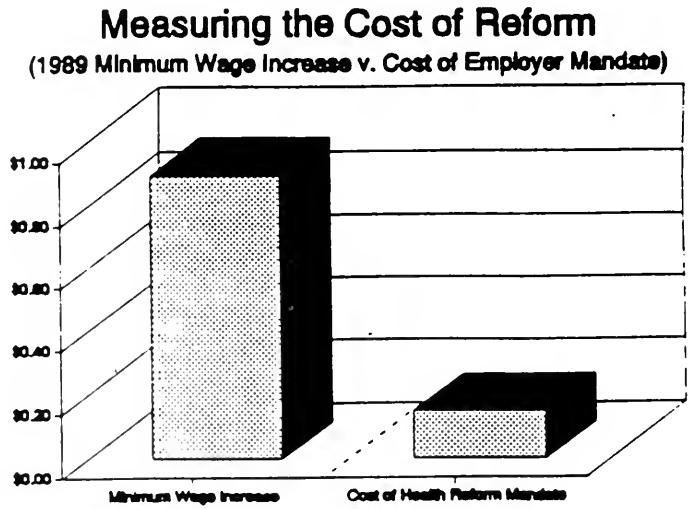
[1] David Card "Do Minimum Wages Reduce Employment? A Case Study of California, 1987–89," *Industrial and Labor relations Review,* October 1992, v.46, n.l, pp.38–54.)

[2] David Card, "Using Regional Variations in Wages to Measure the Effects of the Federal Minimum Wage," *Industrial and Labor Relations Review,* October 1992, v.46, n.l, pp.22–37.)

[3] Larry Katz and Alan Krueger, "The Effect of the Minimum Wage on the Fast-Food Industry," *Industrial and Labor relations Review,* October 1992, v.46, n.1. pp.6–21.)

crease in the minimum wage signed into law by President Bush in 1989. For larger firms with such workers, the cost would be no more than 35 cents per hour.

Given the overwhelming evidence that an employer mandate will have a minimal impact on employment, one can only conclude that the mandate's opponents must be motivated by partisanship and ideology. Their arguments have no basis in fact.



It is also untrue that the Health Security Act will eliminate part-time jobs. It's true that employers would no longer have an incentive to hire part-time, temporary, or contract workers simply to avoid paying for health care coverage. But the plan isn't biased against part-time work either since premiums are pro-rated for part-time workers.

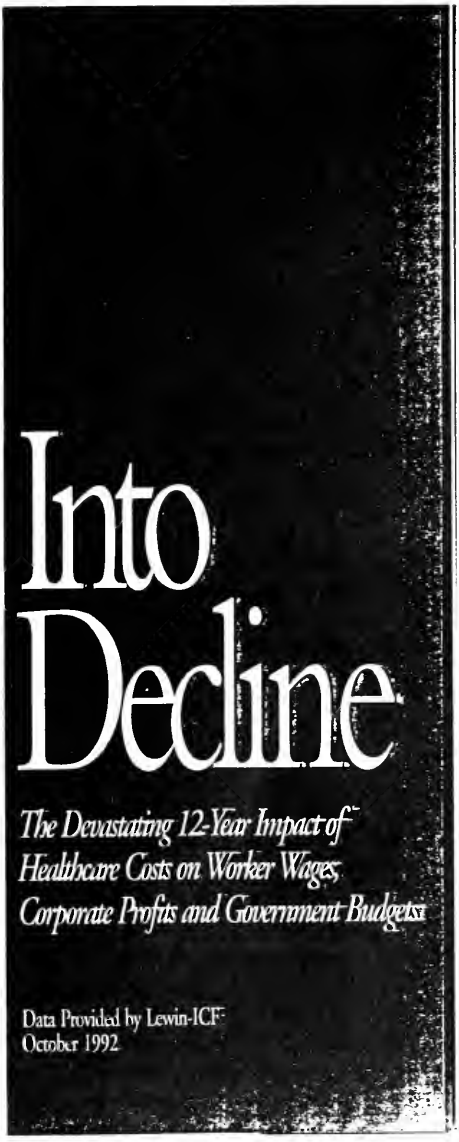
While some previously uninsured workers may see smaller wage increases as the mandate is phased in, all workers will benefit from controlled health care costs. In a study SEIU published with Lewth-VHI, we reported that the failure to control health care costs since 1980 meant that the average worker took the equivalent of a five percent cut in take-home pay in 1992.

Few studies of the Health Security Act have attempted to quantify the job gains from businesses whose costs will fall under health care reform. From a broad economic perspective, however, a mandate could create jobs by reducing distortions in the market caused by the inequitable distribution of health care costs. A recent study from the Economic Policy Institute, for example, found that firms in the manufacturing sector will save $18 billion compared to their expenditures under the current system. These savings will increase manufacturing-related employment by 112,800 jobs during the first five years after the plan is implemented.

Nor has much attention been paid to the potential for job losses if we continue on our present course. A 1992 study by the University of North Carolina School of Public Health found that our failure to control health care costs over the last decade resulted in one million fewer jobs being created. The study also found that rising health care costs will lead to the elimination of 1.5 million jobs over the next five years.

To conclude, let me say that the Health Security Act, and the President's political commitment to health care reform, offers the best hope for achieving our long sought goal of universal health coverage.

Out of Control



A Study by the
Service Employees International Union, AFL-CIO, CLC

The problem of rapidly rising healthcare costs in our country is well-known and widely discussed. Healthcare costs increasing at twice the rate of inflation have pushed 35 million Americans, two-thirds of them workers and their families, into the ranks of the uninsured. Polls consistently show that Americans view high costs as the main problem with health care. A recent national survey by Greenberg-Lake, commissioned by the Service Employees International Union, shows that healthcare costs are the biggest reason 84 percent of American voters favor major reform of our healthcare system.

The problems unions are having with healthcare costs are also well-documented. Health insurance benefits have become the toughest issue at the bargaining table, with rising costs crowding out other components of the compensation package, cutting into worker wages and other benefits. Faced with escalating costs, employers have increasingly demanded that workers accept premium co-payments, higher deductibles and lower wage increases. The result is that healthcare costs are the number one cause of labor disputes.

But what exactly has been the impact of rising healthcare costs on the real wages of workers? How much more would workers have earned over the past 12 years if healthcare costs had grown only as fast as GNP (8.3 percent annually) instead of at 12.5 percent annually? How much more would working families have had in their pocketbooks? How much could they have saved? How much would companies have saved and how would it have affected U.S. competitiveness? And how would state and local government budget deficits have been affected?

To help answer these questions, the Service Employees International Union, with more than one million members in a variety of service occupations, commissioned Lewin-ICF to examine the impact of out-of-control healthcare costs on the wages and living standards of American workers. Lewin-ICF also compiled

Major Findings

This analysis quantifies, for the first time, the impact of rampant healthcare costs on American family incomes, businesses, and government budgets. It is, in a very real sense, a damage report. The findings prove that out-of-control healthcare costs have been a major factor in the decline of personal wages and family well-being since 1980. Moreover, the report establishes healthcare costs as an important contributor to the non-competitiveness of American businesses as well as to state and federal budget deficits. It is clear that economic rebuilding in the U.S. is not possible without stringent measures to contain healthcare costs.

Due to out-of-control healthcare costs, American working families took the equivalent of a five percent cut in take-home pay in 1992 alone.

If healthcare costs had been kept under control since 1980 — that is, if they had grown only at the rate of overall growth of the economy (an average 8.3 percent a year for the last 12 years):

- Personal wages would not have declined;
- The average working family could have saved $12,000;
- Employers would be paying an average $1,015 less per employee per year for health insurance coverage;
- The smallest businesses would be helped even more and would be paying an average $1,283 less per employee per year for health coverage;
- U.S. companies would be more competitive, with health care in the U.S. consuming roughly the same proportion of GNP as it does with our major trading partners (instead of 1.5 to two times as much);
- Our states would have an extra $34.9 billion available in 1992 — enough to close all but $4.8 billion of the $39.7 billion projected total of state budget deficits;
- The federal government would have saved $79 billion in 1992 alone — enough to cut this year's federal deficit by 27 percent.

data on the impact of health costs on the competitiveness of American businesses and the budget deficits staggering 34 states and countless cities and counties in our country.

Lewin-ICF, a leading consulting firm in the area of health economics, conducts data analysis for the U.S. Department of Health and Human Services, the Heritage Foundation, the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission), the 1991 Advisory Council on Social Security, the Brookings Institution and numerous state governments.

Is it realistic to assume that cost increases can be limited to the rate of growth of the economy? Other countries do. Their experience indicates there are a variety of ways to control costs, whether a healthcare system is publicly or privately financed. In fact, the U.S. is unique among industrialized nations because it is the only country that relies almost exclusively on the private marketplace to control costs. And the U.S. is virtually alone in not holding healthcare costs constant as a share of GNP.

Some major healthcare reform plans now being debated propose to control costs by limiting costs to a share of GNP. Others continue to recommend reliance on market forces. The Lewin-ICF analysis is strong historical evidence of the failure of the latter.

We can't get ahead." "My family is falling further behind." The stagnation and decline of American family incomes is one of the most powerful and well-known phenomenons of the last decade. Adjusted for inflation, most workers earn less per hour today than they did in 1980 — 4.4 percent less, on average.[1]

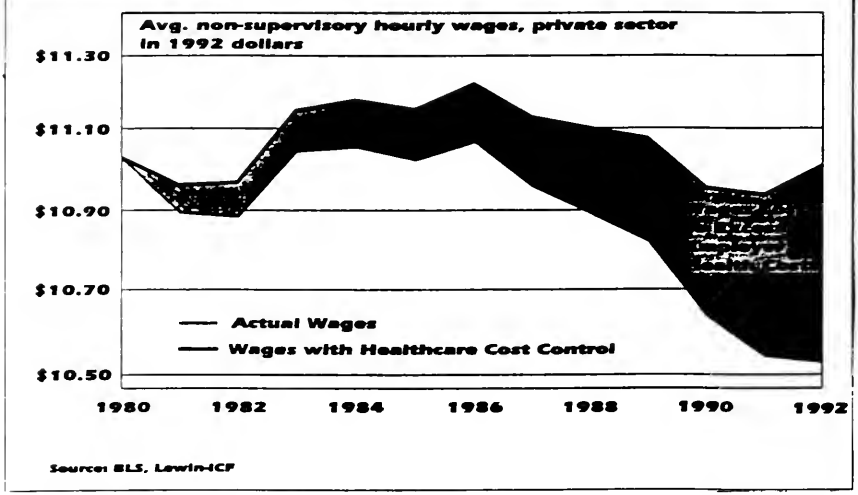
Slow productivity growth and structural changes in the U.S. economy contribute to falling wages. Unchecked healthcare costs are also a major factor.

What would have happened to wages over the last 12 years if healthcare costs had not run wild (that is, if they had grown only as fast as the economy at 8.3 percent instead of 12.5 percent annually)? According to data from Lewin-ICF, there would have been *no decline* in personal wages.

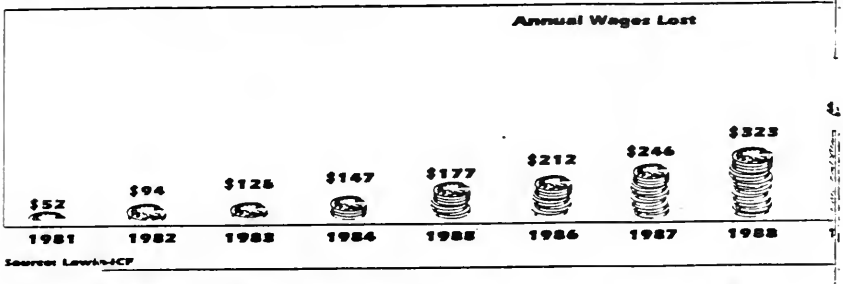
In each of the last 12 years, out-of-control employer health costs are up dollars that would otherwise have gone to wage increases. Lewin-ICF estimates that every dollar increase in employer health premiums costs workers 88 cents in wages.

If wages had not been lost since 1980 to excess employer health costs (the portion of cost increases in excess of the growth rate of the economy), the average hourly non-supervisory wage today would be about 50 cents higher — $11.01 — instead of $10.55 per hour. Instead of losing ground, most workers would have stayed even.

Wages Would Not Have Declined Except for Out-Of-Control Health Costs

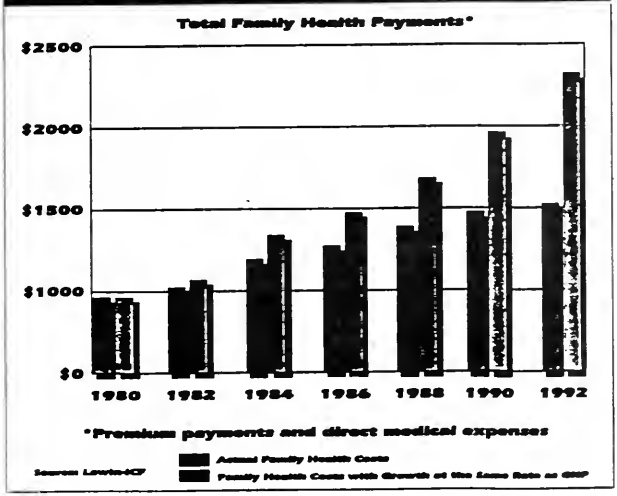


Working Families Lost $4008 in Wages To Out-of-Control Health Premium Costs . . .

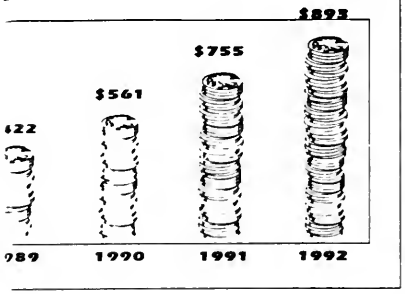


Sources: Lewin-ICF

. . . And Families Lost Even More Because of Rising Out-of-Pocket Costs



Out of Control, Iam Decline



According to Lewin-ICF, every insured worker in the U.S. lost an average $4,008 in pay over the past 12 years — $893 in 1992 alone.[2]

Double-digit increases in employer health costs over the last four years have accelerated the decline, with roughly half of the wage loss occurring since 1989.

Because of out-of-control healthcare costs, the average insured worker lost $422 in wages in 1989, $561 in 1990, $755 in 1991, and $893 in 1992.

But lost earnings due to employer insurance costs are only one part of the picture. Working families had a second bite taken from their purchasing power in the form of direct out-of-pocket family health costs — health insurance premium co-payments, deductibles and other medical expenses — that also grew far faster than inflation over the past 12 years. Lewin-ICF estimates that average out-of-pocket family health spending rose from $939 in 1980 to $2,303 in 1992, a 145 percent increase.

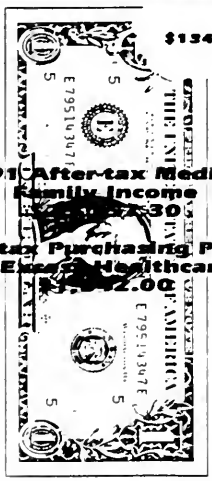
This year alone, working families will pay an average $767 more than they would have paid if healthcare costs had been held to the growth rate of the overall economy since 1980.

What is the combined effect of lower wages and higher out-of-pocket health payments due to excess health costs on the standard of living in our country?

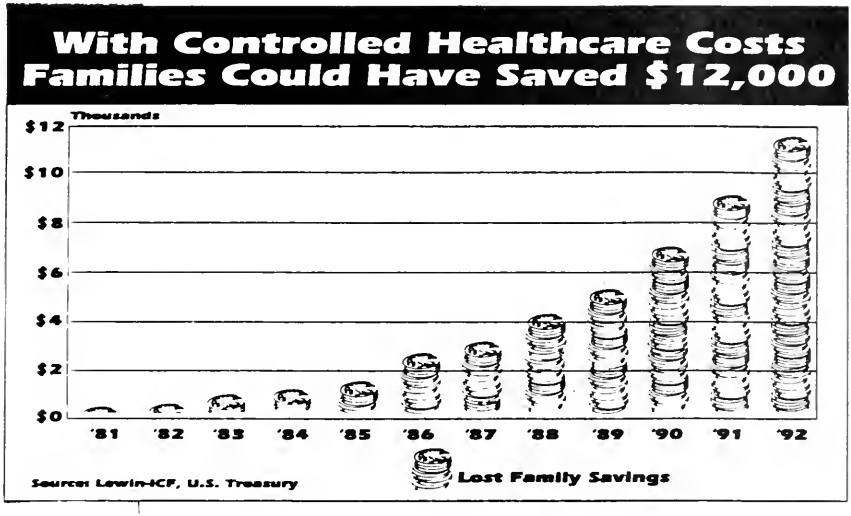
In 1992 alone, working families with health insurance took the equivalent of a 5.3 percent cut in take-home pay because of excess health costs. (The appendix provides estimates of the 1992 impact on working families state by state.)

Exorbitant healthcare costs also undermine families' ability to save money. Savings rates and rates of home ownership for young American

Working Families Lost 5% of Take-home Pay in 1992



Sources: Lewin-ICF, U.S. Census Bureau. Aftertax income of $32,157.89 is based on a 1991 median family income of $32,939, with total tax rate for a median family of 26 percent. Lost purchasing power is lost wages and increased out-of-pocket spending due to excess healthcare costs combined.



families have fallen precipitously since 1981, tracking the whack families took from high healthcare costs. The percentage of disposable personal income to savings has dropped from 8.8 percent to 5.3 percent since 1981.[3] And only 51 percent of 30 - 34 year olds owned homes in 1991, down from 61 percent in 1980.[4]

The average working family could have saved almost $12,000 from 1980 to 1992, if they had put in the bank the income lost to out-of-control healthcare costs.[5]

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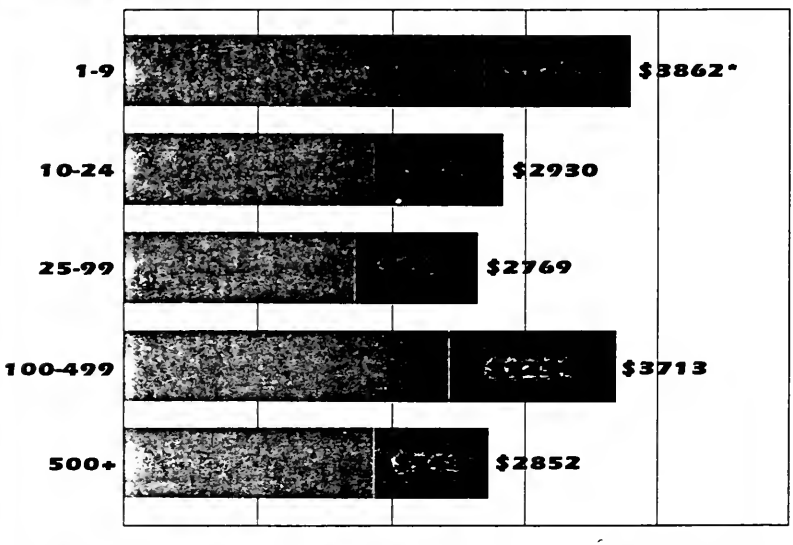
In recent years, employer spending on medical plans has jumped to 61 percent of before-tax corporate profits, devouring resources needed to improve wages, productivity and capital investment.[6]

Today, one-third of business healthcare costs — $1,015 of the $3,054 spent per employee per year, on average — is attributable to excess healthcare cost growth in the last 12 years.

The smallest businesses (those with fewer than 10 employees) currently providing health coverage have been hurt the most by out-of-control health costs. If health spending had not grown out of proportion to the economy, small businesses would be paying $2,579 instead of $3,862 per employee per year for health coverage — a savings of $1,283 per employee per year. And wages for employees of the smallest businesses would be helped the most by keeping health costs in line.

The impact of raging healthcare costs on business competitiveness is substantial. Other industrialized countries spend much less on health care than the U.S. and these differences give countries like Germany and Japan a strong

Employers Would Save $1,015 Per Employee Per Year If Costs Were Controlled— Small Businesses Save Most



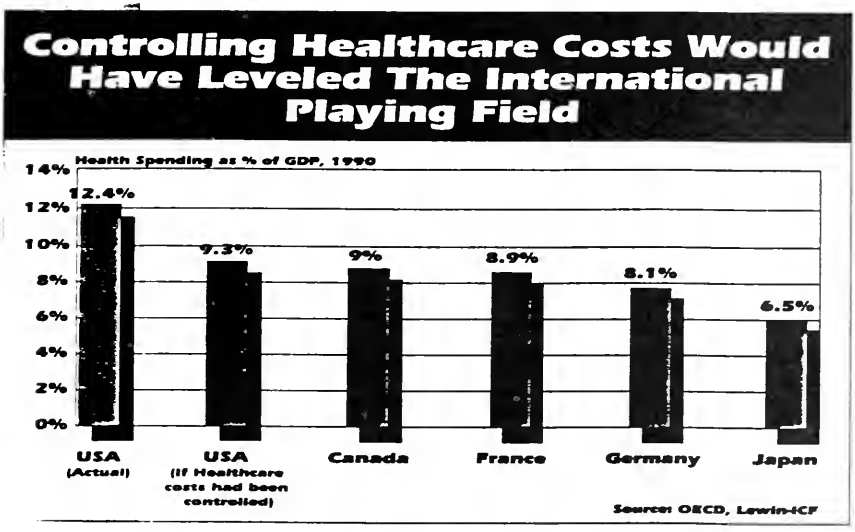
competitive edge. U.S. auto companies estimate that health care adds more than $1,000 to the cost of each American car. Lost jobs is just one result.

Today, health costs consume nearly 14 percent of U.S. gross domestic product, up from nine percent in 1980.

If excess health costs had been cut out by limiting the growth of health spending to the rate of growth of GNP in the last decade, health spending today would be 9.3% — putting U.S. companies in an improved competitive position compared to companies in Canada (with health spending at 9 percent of GDP), France (8.9 percent), Germany (8.1) and Japan (6.5). All these countries provide health care to virtually all their citizens at this lower level of spending, while the U.S., despite its high spending, has 35 million citizens without health insurance.

The need to compete in the face of rising healthcare costs in turn exerts pressure on businesses to pass costs on to employees in the form of higher out-of-pocket healthcare payments and lower wages, resulting in less purchasing power, a lowered standard of living, lower savings rates, and downward pressure on the economy.

And inflated health costs also penalize mature U.S. industries that employ older, more experienced workers relative to companies with younger workers, discouraging companies from investing in a productive, long-term work force.



Controlling Health Costs Would Have Closed States' Budget Gap

Projected State Budget Shortfalls, 1992
$39.7 Billion

Revenues Lost to Out-Of-Control Healthcare Costs
$34.9 Billion

Source: Lewin-ICF, Bureau of Economic Analysis

If healthcare costs had been held to the rate of economic growth since 1980, Lewin-ICF estimates that the cumulative national savings in current dollars would be $1.2 trillion — $269 billion for 1992 alone.

For fiscally-strapped state and local governments, out-of-control health costs have had a critical impact. Health care is the fastest growing item in state and local government budgets — with one-fifth of their budgets spent on medical care.

If healthcare costs had been held in check, states would have an extra $34.9 billion in 1992 — enough to close all but $4.8 billion of the $39.7 billion projected total state budget shortfalls.[7]

Over the last 12 years, the failure to control healthcare costs has cost state and local governments $159.1 billion (in 1992 dollars) — money sorely needed in other areas. If, for instance, the excess state healthcare costs in each year since 1980 had instead been added to spending for schools, the budget of every public elementary, middle and high school would be 75 percent higher today.[8]

And the problem is worsening. The rising state share of Medicaid costs — already at 14 percent of state expenditures and one of the most devastating contributors to state budget deficits — will double to 28 percent of state expenditures by 1995 if costs continue to rise at current rates.[9]

The impact of excessive health costs on the federal budget is equally dramatic. In 1980, one of every nine dollars spent by the federal government went to health care. By 1996, that share could virtually double to one out of every five dollars, crowding out other budget needs. For

instance, while education spending has remained constant as a percentage of GNP over the last 12 years and defense spending has been cut slightly, healthcare spending has increased its share of GNP by 50 percent.

If health costs had been controlled to the rate of growth of the economy, the federal government would have saved $79 billion in 1992 alone — enough to have cut this year's deficit by 27 percent.[10]

And over the last 12 years, the federal government would have saved $391.2 billion — enough, for instance, to fully fund all federal grant programs to states and localities at 1982 levels plus have an additional $160 billion left for reducing the national debt and investing in education and training.[11]

What's ahead? The U.S. Department of Commerce anticipates that if current trends are unchecked, healthcare costs will continue to rise by 12 to 15 percent annually over the next five years. And health care will consume more of workers' earnings — doubling as a percentage of GNP by the end of the decade.

Unless excess health spending is cut out through serious reform of the healthcare system with strong cost controls, Americans can expect to pay more for less health care and watch their standard of living continue to decline.

Without health cost reform, American businesses will be uncompetitive, and the economy will be unable to grow. Resources needed to rebuild our roads, educate our children and increase productivity will instead be absorbed by an out-of-control healthcare system. It is axiomatic that national healthcare reform is at the core of any economic rebuilding strategy.

Endnotes

[1] Changes in wages were calculated using the average hourly wage for all non-supervisory private sector workers published by the Bureau of Labor Statistics. This wage series includes both insured and uninsured workers.

[2] Calculation is based on 88 percent of excess employer spending on health care (the amount beyond the growth in GNP) per insured worker.

[3] Personal savings rates are from *Economic Report of the President*, February 1992.

[4] Homeownership rates are from the U.S. Bureau of the Census.

[5] To find the cumulative value of potential savings lost by working families, the annual reduction in health spending and increased wages were assumed to be invested at the ten-year Treasury bond rate. The value of each year's investment by 1992 was summed.

[6] Employer health costs as a proportion of corporate profits is from "Business, households, and governments: Health care costs, 1990," *Health Care Financing Review*, Winter 1991.

[7] Federal, state and local shares of national health spending are from estimates by the Office of the Actuary, Health Care Financing Administration.

[8] Education spending figures are from the Department of Education.

[9] Projections of the Medicaid burden on state budgets are from the National Association of State Budget Officers.

[10] Calculation is based on Congressional Budget Office estimate of federal budget deficit of $290 billion in fiscal year 1992, which ended September 30, 1992.

[11] Estimate of cumulative federal savings is the federal share of excess health spending since 1982 stated in 1992 dollars. Estimate of shortfall in federal grants-in-aid to states and localities is from AFSCME's *The Republican Record: A 10-Year Analysis of State Losses of Federal Funding (FY 1982 - FY 1991).*

Table 1

HEALTH SPENDING REDUCTIONS AND INCREASED EARNINGS IN 1992 ASSUMING THAT HEALTH SPENDING HAD GROWN AT THE RATE OF GROWTH OF GNP STARTING IN 1981, BY STATE, FOR WORKING FAMILIES

State	Increased Earnings		Reduction in Health Expenditure per Family[a]	Expenditure Reduction plus Increased Earnings per Family
	Per Worker With Insurance[a]	Per Family[b]		
UNITED STATES	$850	$818	$721	$1,539
ALABAMA	$655	$574	$720	$1,294
ALASKA	$975	$982	$725	$1,707
ARIZONA	$869	$754	$578	$1,332
ARKANSAS	$475	$424	$595	$1,019
CALIFORNIA	$1,086	$998	$750	$1,748
COLORADO	$950	$866	$661	$1,528
CONNECTICUT	$1,101	$1,154	$834	$1,988
DELAWARE	$598	$586	$658	$1,245
DISTRICT OF COLUMBIA	$516	$410	$447	$857
FLORIDA	$604	$522	$673	$1,195
GEORGIA	$573	$558	$646	$1,204
HAWAII	$1,071	$1,103	$745	$1,849
IDAHO	$607	$619	$500	$1,119
ILLINOIS	$1,058	$1,033	$854	$1,886
INDIANA	$835	$805	$719	$1,524
IOWA	$872	$851	$760	$1,612
KANSAS	$1,016	$1,013	$857	$1,870
KENTUCKY	$485	$440	$532	$973
LOUISIANA	$593	$515	$640	$1,154
MAINE	$824	$819	$667	$1,486
MARYLAND	$631	$627	$669	$1,296
MASSACHUSETTS	$1,189	$1,175	8497	$2,024
MICHIGAN	$1,045	$985	$819	$1,804
MINNESOTA	$1,011	$1,018	$810	$1,829
MISSISSIPPI	$438	$391	$521	$912
MISSOURI	$1,010	$963	$831	$1,794
MONTANA	$628	$622	$506	$1,128
NEBRASKA	$978	$978	$845	$1,823
NEVADA	$1,017	$940	$695	$1,635
NEW HAMPSHIRE	$793	$829	$680	$1,509
NEW JERSEY	$903	$918	$699	$1,617
NEW MEXICO	$615	$566	$511	$1,078
NEW YORK	$1,015	$917	$746	$1,663
NORTH CAROLINA	$511	$500	$589	$1,089
NORTH DAKOTA	$973	$986	$863	$1,849
OHIO	$969	$926	$796	$1,722
OKLAHOMA	$545	$498	$633	$1,131
OREGON	$818	$756	$610	$1,366
PENNSYLVANIA	$975	$913	$779	$1,692

Table 1 continued

State	Increased Earnings		Reduction in Health Expenditure per Family[c]	Expenditure Reduction plus Increased Earnings per Family
	Per Worker With Insurance[a]	Per Family[b]		
RHODE ISLAND	$1,036	$1,001	$803	$1,805
SOUTH CAROLINA	$495	$491	$522	$1,013
SOUTH DAKOTA	$885	$886	$790	$1,677
TENNESSEE	$588	$552	$696	$1,248
TEXAS	$623	$608	$740	$1,348
UTAH	$826	$881	$635	$1,515
VERMONT	$736	$758	$631	$1,390
VIRGINIA	$593	$605	$664	$1,268
WASHINGTON	$787	$756	$573	$1,329
WEST VIRGINIA	$548	$445	$618	$1,063
WISCONSIN	$955	$952	$785	$1,737
WYOMING	$656	$696	$523	$1,219

a Working families are defined to include all families where the family head is employed.

b Under this scenario, average employer health spending per worker in 1992 would have been 31.6 percent lower than actual spending in 1992. We assume that 88 percent of these savings to employers would have been converted to wages and salaries.

c Total increased earnings divided by the number of families.

d Includes reductions in household premium payments and direct health expenditures.

Lewin-ICF Methodology

National Aggregates

The first step in constructing the estimates was to establish baseline values for the key variables for the period from 1980 to 2000. The key variables are GNP, national health expenditures, employer health insurance premium payments, household premium payments, direct household health expenditures, wages, and compensation. Most data used are HCFA estimates, as reported in three published documents plus two unpublished supporting tables.[1] These are supplemented with historical data from the *Economic Report of the President, 1992*. Projected values for some variables are interpolated in some years.

The second step was to construct estimates of national health expenditures, employer health insurance premium payments, household premium payments, direct household health expenditures, and wages under each of two scenarios: (1) if national health expenditures grow at the same rate as GNP from 1994 to 2000, and (2) if national health expenditures had grown at the same rate as GNP from 1981 to 1992.

Under both scenarios, we assume that both employer and household health insurance premium payments, as well as direct household health expenditures, will be reduced in proportion to the reduction in national health expenditures. For example, if national health expenditures under a scenario in a particular year are five percent below baseline values, premium payments and direct household expenditures are also reduced by five percent from their respective baseline values. No doubt implementation of measures that would control growth in national health expenditures would result in reductions in growth of various components that are not proportional, but at this stage it is not possible to predict which components would be reduced less than proportionately and which would be reduced more. Should premium payments and direct household expenditures fall proportionately more than national health expenditures, the effects on wages and health expenditures would be greater than those we have estimated.

We also assume that GNP growth will not be affected by the lower growth rates in national health expenditures. Numerous effects could occur; some are positive and others negative, and it is not possible to predict the direction of the net effect. Some might argue that slowing the growth rate of national health expenditures would have a positive effect on productivity growth since productivity growth has historically been lower in the health care sector than in non-health sectors. Others might argue that methods used to control growth of national health expenditures will require market interventions that will make the economy operate less efficiently, thereby slowing the growth rate of GNP. To the extent that government spending on health care is reduced, the federal budget deficit would be reduced, presumably stimulating growth in the long run, but the actual effect on the deficit will depend on unpredictable decisions about how to use government savings; they could be returned to taxpayers through a reduction in taxes or, alternatively, be spent on something else, rather than used for deficit reduction. Still others might argue that spending controls will cause dislocation of employees who work in the health care sector, at least in the short run, thereby reducing GNP, at least temporarily. There may be some such dislocations, but we expect the number of dislocations to be small since health expenditures would still grow at the rate of GNP; i.e., there would be no reduction in the size of the health care sector, just a slowing of its rapid expansion. On net, we would be surprised if there were a measurable effect of controlling growth in health expenditures on GNP.

We also assume that total worker compensation — wages plus all supplements — will not be affected by the lower growth rate of national health expenditures. Historically, compensation has been extremely stable as a percentage of GNP, at 60 percent plus or minus less than one percentage point, and has been invariant both to substantial increases in the share of employer premium payments in total compensation, and to tax and other policy changes that have direct effects on components of compensation (e.g., changes in the rate for employer contributions to Social Security).

Some would argue that some industries may be able to pass on higher insurance premium payments to customers or to shareholders. If so, then it would be unlikely that slowing the growth rate of employer insurance costs would result in more rapid wage growth. This argument is largely fallacious in a world where the customers of most industries can buy competitive products from abroad or from non-unionized producers, and the owners (shareholders) can invest their money elsewhere.

Given no change in aggregate compensation, reductions in employer health premium payments must be exactly offset by increases in wages and non-health wage supplements. We assume that increases would be allocated to these two categories in proportion to their baseline levels, which vary somewhat from year to year. In the baseline data for 1992, wages constitute about 88 percent of wages plus non-health wage supplements. Hence, a one dollar reduction in employer premiums in that year is assumed to increase wages by 88 cents. We adopted this assumption because the most important items that make up non-health supplements are, for most workers, proportional to their wages. Over half of these supplements are employer contributions to Social Security and Medicare, which are by law proportional to a worker's wages up to maximum amounts that are not reached by most workers. Employer

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[1] K. R. Levit, H. C. Lazenby, C. A. Cowan, and S. W. Letsch, "National Health Expenditures, 1990," *Health Care Financing Review*, Vol. 13, No. 1, Fall 1991, 29-52; K.R. Levit and C.A. Cowan, "Business, Households, and Governments: Health Care Costs, 1990," *Health Care Financing Review*, Vol. 13, No. 2, Winter 1991, 83-93; Board of Trustees of the Federal Old Age and Survivors Insurance and Disability Insurance Trust Funds, *1991 Annual Report*

contributions to private pension plans are the next most important component, and they, too, are often proportional to wages. To the extent that some components of non-health wage supplements are fixed, rather than proportional to wages, our assumption understates the effect of a reduction in employer premium payments on wages.

While the effects of reduced growth in national health expenditures on GNP and aggregate compensation are likely to be negligible, there could be substantial effects on production and compensation in some industries and regions of the country, and these will undoubtedly result in at least some movement of workers between sectors and regions. The reason is that the effects of reducing employer health premiums will increase with the size of the firm's current premium payments, and these are not uniformly distributed across industries and regions. We would expect employment to increase in those industries and regions where employers typically pay relatively large premiums, and to decline in those where employers typically pay relatively low premiums. Note that movement of workers from low premium firms, which include those that do not have health plans, to high premium firms would tend to increase the proportion of workers who obtain coverage under their employer's plan. We make no attempt at predicting the magnitude of such changes, and our estimates of effects by firm size, industry, and state, do not take such changes into account.

Family Income, Firm Size, and Industry Distributions

Given our national aggregate estimates under each of the two scenarios, the next step is to produce estimates by family income, firm size, and industry — in 2000 under the first scenario and in 1992 under the second. We began this process by using Lewin-ICF's Health Benefits Simulation Model (HBSM) to generate baseline distributions of employer premiums for covered workers by firm size and industry, and for employer premiums, household premiums, and direct household health expenditures by working family, in both 1992 and 2000.[2]

The Health Benefit Simulations Model (HBSM) is a microsimulation model that provides first order estimates of the impact of health reform proposals, both at the individual household level and at greater levels at aggregation. HBSM is used to generate estimates of the cost of a specified health care finance and access proposal shared by households, employers, state governments, and federal government.

The household data used by HBSM contains records detailing individuals' use of health care services in a given year, and a variety of demographic information. Including the age, gender, minority status, and number of members of a given household. The model also uses survey information on the level and sources of household income. This is needed both to determine eligibility for various proposed programs and to determine the payments required of members of the household.

The data base used by HBSM is synthesized from several data sources including: the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES), the March 1991 Current Population Survey (CPS), the National Health Interview Survey (NHIS) for the years 1980-1986, the Lewin-ICF Survey of Employer Health Plans, and the 1991 National Health Accounts. The primary data source in the analysis is the 1980 NMCUES, a national survey of about 6,400 civilian, non-institutional families.

Although NMCUES represents the most recent and complete set of micro-data on household health care utilization currently available, the survey data is outdated and must be "aged" to represent the demographic and economic characteristics of the population in the simulation year.

The 1992 and 2000 baseline distributions produced by the model were controlled to the national aggregate estimates of premiums and direct household health expenditures. Since working families, as we have defined them, do not account for all premium payments and direct household health expenditures, we used the HBSM to estimate the proportion of each accounted for by such families and then applied these to the aggregate estimates before controlling the HBSM distributions for these variables to the aggregate estimates.[3]

We assumed that employer premium payments per insured worker within each firm size and industry category would decline in proportion to the national reduction in employer premium payments and that the savings from lower premium payments would be converted to higher wages at the same rate as in the aggregate estimates.

We also assumed that average household premium payments and direct household health expenditures for working families would be reduced in each income category in proportion to the aggregate reduction in these expenditures.

State Distributions

The final step in the estimation process was to produce the state tables. To complete this step, we first used the HBSM along with tabulations from a Lewin-ICF extract of Current Population Survey (CPS) data, Bureau of the Census estimates and projections of the population by five year age group, and HCFA estimates of health expenditures by state from 1982, the most recent year for which such estimates are available.

To generate health spending estimates by state, HBSM estimates of employer premium payments, household premium payments, direct household health expenditures, Medicare, Medicaid, and other public expenditures within family income,

[2] For the purposes of this report, "working families" include all families with an employed head-of-household. This excludes a few families in which the head-of-household is not employed, but someone else in the household is. We estimate that working families, as we have defined them, account for over 95 percent of all employment-based health insurance.

[3] For 1992, working families accounted for 95.6 percent of employer premium payments, 70.7 percent of household premium payments, and 74.0 percent of direct household health spending. For 2000, the corresponding percentages are projected to be 95.6, 73.7 and 74.1 percent, respectively.

age of head, insurance status and family size categories were applied to CPS data on the distribution of families by income, age of head, health insurance status, and family size, as well as distributions of workers by age and health insurance status by state in 1982. The resulting expenditures by state were controlled to HCFA estimates of health spending by state in 1982. These values were then aged to 1992 to reflect changes in the population and health spending over the period. The resulting distributions were then controlled to aggregate baseline estimates for 1992 to get baseline estimates for employer premium payments and household health spending (household premiums plus direct health spending) by state.

We then estimated the number of families and the number of insured workers in each state for 1991. Bureau of the Census estimates of the size and age distribution of the population, by state, were used to age the numbers of workers and families to 1992.

The earnings increases were generated by assuming that employer premium payments in each state would fall proportionately to the aggregate reduction, and that the reduction in premium payments would be converted to increased wages at the aggregate rate. The reductions in household health expenditures (household premium payments plus direct household health expenditures) for working families were computed by assuming that the decline in each state would be proportional to the aggregate decline.

Table 2

BASELINE ESTIMATES AND PROJECTIONS (IN BILLIONS)

Year	Gross National Product[1]	National Health Expenditures[2]	Employer Health Insurance Premium Payments	Household Health Insurance Premium Payments[3]	Direct Household Health Expenditures[4]	Wages[5]	Total Compensation[6]
1980	$2,732.0	$250.1	$57.3	$16.2	$59.5	$1,376.6	$1,644.4
1981	$2,988.6	$290.2	$68.4	$18.6	$67.2	$1,515.6	$1,815.5
1982	$3,245.2	$326.1	$79.7	$20.8	$74.2	$1,593.3	$1,916.0
1983	$3,501.8	$358.6	$90.3	$21.1	$81.4	$1,684.2	$2,029.4
1984	$3,758.4	$389.6	$97.3	$26.4	$87.7	$1,850.0	$2,226.9
1985	$4,015.0	$422.6	$105.7	$28.4	$94.4	$1,986.3	$2,382.8
1986	$4,232.0	$454.8	$114.2	$28.9	$100.9	$2,105.4	$2,523.8
1987	$4,516.0	$494.1	$119.5	$35.3	$108.8	$2,261.4	$2,698.7
1988	$4,874.0	$546.0	$139.5	$34.9	$119.3	$2,443.0	$2,921.3
1989	$5,201.0	$602.8	$157.2	$39.2	$126.1	$2,585.8	$3,101.3
1990	$5,465.0	$666.2	$174.2	$42.6	$136.1	$2,738.9	$3,290.3
1991	$5,630.0	$738.2	$196.3	$47.3	$151.5	$2,807.7	$3,387.7
1992	$6,045.0	$809.0	$210.8	$50.1	$166.9	$3,004.9	$3,627.0
1993	$6,446.2	$896.9	$233.1	$54.6	$175.7	$3,197.0	$3,867.7
1994	$6,852.3	$984.8	$255.9	$59.0	$190.5	$3,391.3	$4,111.4
1995	$7,284.0	$1,072.7	$279.8	$63.5	$213.2	$3,598.1	$4,370.4
2000	$9,863.0	$1,615.9	$419.4	$88.2	$290.3	$4,837.4	$5,919.0

[1] Source: *Economic Report of the President, 1992* and Health Care Financing Administration (HCFA) for 1980 to 1990, and HCFA projections thereafter.

[2] Source: HCFA estimates and projections. Values for 1993 and 1994 were interpolated, assuming a constant growth rate from 1992 to 1995.

[3] These include premium contributions from private employers plus federal, state and local governments. The 1980 to 1990 values are from HCFA. HCFA does not present projections. HCFA does, however, project total private medical payments. From 1980 to 1990 employer contributions increased from 78.17 percent of all payments to 80.40 percent. We assume that they would continue to increase as a percent of all payments at the same percentage change per year as in the previous decade; by 2000, the percentage is 82.6 percent.

[4] These include employee contributions to employer provided insurance as well as premium payments for independent plans. The 1980 to 1990 values are from HCFA. For 1991 to 2000, these values are HCFA's projections of total private insurance payments minus employer payments.

[5] These are BEA historical estimates for 1980 to 1990 and projections for 1991 to 2000. Values for 1993 and 1994 are interpolated, assuming a constant rate of growth from 1992 to 1995.

[6] Wages and salaries are from the *Economic Report of the President, 1992* for 1980 to 1991. For the projections, we assumed that wages and salaries would be a constant share of compensation minus employer premium payments. The share used is from 1991, 87.96 percent.

[7] Compensation includes wages and salaries, and employer contributions to social security, Medicare, private pensions, unemployment insurance, workers compensation insurance, and other wage supplements. For 1980 to 1991 the data are from the *Economic Report of the President, 1992*. Compensation is projected to be 60 percent of projected GNP for 1992 through 2000.

Table 3

NATIONAL HEALTH EXPENDITURES WITH AND WITHOUT COST CONTROLS, 1980-1992 (In Billions)

Year	Health Expenditures		
	Actual (Without Cost Controls)[a]	Estimated (With Cost Controls)[b]	Estimated Reduction
1980	$250.1	$250.1	$ 0.0
1981	290.2	273.6	16.6
1982	326.1	297.1	29.0
1983	358.6	320.6	38.0
1984	389.6	344.1	45.5
1985	422.6	367.6	55.0
1986	454.8	387.4	67.4
1987	494.1	413.4	80.7
1988	546.0	446.2	99.8
1989	602.8	476.1	126.7
1990	666.2	500.3	165.9
1991	738.2	517.2	221.0
1992	809.0	540.4	268.6
		Cumulative Reduction	$1,214.2

a Health Care Financing Administration estimates. The 1991 and 1992 values are HCFA's latest projections, made in 1991.

b Assumes that health expenditures grow at the same rate as GNP. GNP for 1980-1991 is from the *Economic Report of the President, 1992.* The 1992 value is the mid-year projection of the Department of Commerce, which is about 2.4 percent lower than the HCFA projection that is used in the body of the report.

Source: Lewin-ICF estimates.

Table 4

EMPLOYER HEALTH INSURANCE PREMIUM PAYMENTS PER INSURED WORKER WITH AND WITHOUT COST CONTROLS, 1980-1992

Year	Employer Premium Payments Per Insured Worker		
	Actual (Without Cost Controls)[a]	Estimated (With Cost Controls)[b]	Estimated Reduction
1980	$ 881	$ 881	$ 0
1981	1,042	982	59
1982	1,202	1,095	107
1983	1,349	1,206	143
1984	1,435	1,267	167
1985	1,547	1,346	201
1986	1,626	1,385	241
1987	1,712	1,433	279
1988	2,012	1,644	367
1989	2,281	1,802	479
1990	2,565	1,926	638
1991	2,867	2,009	858
1992	3,054	2,039	1,015
		Cumulative Reduction	$4,560

a For 1980 to 1992, these are Health Care Financing Administration estimates of employer premium payments divided by Employee Benefit Research Institute estimates of insured workers. The 1991 and 1992 employer premium estimates are HCFA's latest projections, made in 1991. The 1992 insured worker estimate is from Lewin-ICF's Health Benefits Simulation Model, and the 1991 estimates is interpolated.

b Assumes that reductions in employer premium payments are proportional to reductions in overall health expenditures.

Source: Lewin-ICF estimates

Table 5

HOUSEHOLD HEALTH INSURANCE PREMIUM PAYMENTS PER FAMILY WITH AND WITHOUT COST CONTROLS, 1980-1992

Year	Household Premium Payments Per Family		
	Actual (Without Cost Controls)[a]	Estimated (With Cost Controls)[b]	Estimated Reduction
1980	$201	$201	$ 0
1981	227	214	13
1982	253	230	22
1983	253	226	26
1984	311	274	36
1985	328	285	42
1986	330	281	48
1987	396	331	64
1988	384	314	70
1989	429	339	90
1990	461	346	115
1991	505	354	151
1992	532	354	178
		Cumulative Reduction	$860

a For 1980 to 1990, these are Health Care Financing Administration estimates of household premium payments divided by Bureau of Census estimates of the number of households. The 1991 and 1992 household premium estimates are HCFA's latest projections, made in 1991. The 1991 and 1992 estimates of households are from Lewin-ICF's Health Benefits Simulation Model. Bureau of the Census estimates of households were adjusted downward by 2.2 percent to correct for a difference between their household definition and that used by Lewin-ICF.

b Assumes that reductions in household premium payments are proportional to reductions in overall health expenditures.

Source: Lewin-ICF estimates.

Table 6

DIRECT HEALTH CARE EXPENDITURES PER FAMILY WITH AND WITHOUT COST CONTROLS, 1980-1992

Year	Direct Expenditures Per Family		
	Actual (Without Cost Controls)[a]	Estimated (With Cost Controls)[b]	Estimated Reduction
1980	$ 738	$ 738	$ 0
1981	822	775	47
1982	904	823	80
1983	976	872	103
1984	1,033	912	120
1985	1,090	948	142
1986	1,153	982	170
1987	1,221	1,021	199
1988	1,314	1,073	240
1989	1,381	1,091	290
1990	1,475	1,108	367
1991	1,619	1,134	484
1992	1,771	1,182	589
		Cumulative Reduction	$2,836

a For 1980 to 1990, these are Health Care Financing Administration estimates of direct expenditures divided by Bureau of the Census estimates of the number of households. The 1991 and 1992 direct expenditure estimates are HCFA's latest projections, made in 1991. The 1991 and 1992 estimates of households are from Lewin-ICF's Health Benefits Simulation Model. Bureau of the Census estimates of households were adjusted downward by 2.2 percent to correct for a difference between their definition and that used by Lewin-ICF.

b Assumes that reductions in direct expenditures are proportional to reductions in overall health expenditures.

Source: Lewin-ICF estimates

Table 7

TOTAL FAMILY HEALTH EXPENDITURES WITH AND WITHOUT COST CONTROLS, 1980-1992

Year	Expenditures Per Family		
	Actual (Without Cost Controls)[a]	Estimated (With Cost Controls)[b]	Estimated Reduction
1980	$ 939	$ 939	$ 0
1981	1,050	990	60
1982	1,157	1,054	103
1983	1,228	1,098	130
1984	1,344	1,187	157
1985	1,418	1,233	184
1986	1,483	1,263	219
1987	1,617	1,353	264
1988	1,698	1,388	310
1989	1,810	1,430	380
1990	1,937	1,455	482
1991	2,125	1,489	636
1992	2,303	1,536	767
		Cumulative Reduction	$3,696

a Household health insurance premium payments plus direct health care expenditures, divided by the number of households.

b Assumes that reductions in family health expenditures are proportional to reductions in overall health expenditures.

Source: Lewin-ICF estimates.

Table 8

ESTIMATED REDUCTION IN FAMILY HEALTH EXPENDITURES PLUS WAGE INCREASES FOR WORKING FAMILIES 1980-1992

Year	Reduction In Family Health Expenditures[a]	Average Increase In Wages For Working Families[b]	Reduction In Health Expenditures Plus Wage Increase For Working Families
1980	$ 0	$ 0	$ 0
1981	60	51	111
1982	103	93	196
1983	130	124	254
1984	157	144	301
1985	184	171	356
1986	219	209	429
1987	264	238	502
1988	310	304	615
1989	380	393	773
1990	482	512	994
1991	636	689	1,326
1992	767	818	1,586
Cumulative	**$3,696**	**$3,751**	**$7,447**

a Lewin-ICF estimates of reductions in the sum of household health insurance premium payments and direct household health expenditures per family.

b Lewin-ICF estimates of increases in average wages for working families.

c This assumes that reductions in family health expenditures for the average working family are the same as for the average family, including non-working families. This assumption is supported by Lewin-ICF analysis of data for 1992: average family health expenditures for working families were estimated to be $6 less than for all families.

Source: Lewin-ICF estimates.

Table 9

REDUCTION IN AVERAGE FAMILY HEALTH EXPENDITURES AND INCREASED EARNINGS PER FAMILY IN 1992 ASSUMING THAT HEALTH SPENDING HAD GROWN AT THE RATE OF GNP SINCE 1981, FOR INSURED WORKING FAMILIES ONLY[a]

Family Income	Reduction In Health Expenditures[b]	Increase In Earnings Per Family[c]	Health Spending Reductions Plus Earnings Increase
Under $10,000	$ 503	$ 595	$1,098
$10,000 - $14,999	435	547	981
$15,000 - $19,999	501	700	1,201
$20,000 - $29,999	594	760	1,353
$30,000 - $39,999	707	894	1,601
$40,000 - $49,999	703	1,046	1,749
$50,000 - $74,999	789	1,279	2,068
$75,000 or more	1,082	1,909	2,991
All Insured Families	**$860**	**$1,136**	**$1,843**

a Insured working families are defined to include all families where the family head is employed and has insurance.

b Includes reduction in premiums and reduced direct payments for care.

c Estimates assume that average employer health spending in 1992 would have been reduced by 31.6 percent for covered workers. We assume that 88 percent of these savings are converted to increased wages and salaries.

Source: Lewin-ICF estimates using the Health Benefits Simulation Model (HBSM).

MEMBERS OF THE NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

Acme Steel Company
Amalgamated Clothing & Textile Workers Union, AFL-CIO
American Academy of Family Physicians
American Academy of Pediatrics
American Association of Retired Persons
American Automobile Manufacturers' Association
American College of Physicians
American Federation of Teachers, AFL-CIO
American Iron & Steel Institute
American Nurses Association, Inc.
American Physical Therapy Association
American Psychological Association
Association of Academic Health Centers
Association of Minority Health Professional Schools
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Giant Food Inc.
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International Brotherhood of Electrical Workers
International Multifoods
International Union of Bricklayers and Allied Craftsmen

James River Corporation
Johnstown Corporation
Keebler Company
Keller Glass Company
Lincoln Telephone & Telegraph Co.
Lockheed Corporation
LTV Steel Company
Lukens Inc.
Maternity Center Association
Maytag Corporation
National Association of Childbearing Centers
National Association of State Boards of Education
National Easter Seal Society
National Education Association
National Steel Corporation
Navistar International Transportation Corporation, Inc.
Norwest Corporation
Olympia West Plaza, Inc.
Pacific Gas & Electric
PAR Associates
Pella Corporation
Preferred Benefits
R. R. Donnelley & Sons Co.
Ralphs Grocery Company
Regis Corporation
Rohm & Haas Company
Safeway Inc.
Sara Lee Corporation
Scott Paper Co.
Service Employees International Union, AFL-CIO
Sokolov Strategic Alliance
Southern California Edison Company
Strategic Marketing Information, Inc.
Texas Heart Institute
Time Warner Inc.
United Air Lines, Inc.
United Food and Commercial Workers International Union, AFL-CIO
United Paperworkers International Union, AFL-CIO
United States Catholic Conference
United Steelworkers of America, AFL-CIO
U.S. Bancorp
The Vons Companies, Inc.
Westinghouse Electric Corporation
Wheat, First Securities, Inc.
Wheeling-Pittsburgh Steel Corp.
The Whitman Group
Wisconsin Public Service Corporation
Xerox Corporation

COMMUNICATIONS

STATEMENT OF THE AMERICAN HOTEL & MOTEL ASSOCIATION

The American Hotel & Motel Association is a federation of associations representing lodging interests in the 50 states, the District of Columbia, Puerto Rico and the Virgin Islands. The Association federation has a membership in excess of 10,000 individual lodging properties which represents approximately 1.3 million rooms. Inclusive in our membership are all of the major hotel and motel chains and a large percentage of independent properties.

The entire industry is made up of approximately 45,000 hotels employing over 1.5 million people to serve over 3 million guest rooms. Unfortunately, the image one tends to get about the hotel/motel industry is distorted by the large convention hotels in our major cities and the mega destinations such as Las Vegas and Orlando. One is left with the impression that ours is an industry dominated by large hotels. Nothing could be further from the truth. Just over two-thirds of our country's hotels have under 75 rooms with likely employment between 25 and 50 employees. Typically a company will operate more than one hotel property and thus will have total employment of over 75 individuals, the subsidy cut-off point under the Clinton health plan. Despite exceeding this small number of employees, many of our hotel companies suffer from all the financial disadvantages endemic in small businesses including an inability to negotiate lower insurance premiums.

We take pride in our industry's job creation and career starting history, but must point out that being a source of entry-level jobs bears extra costs. Frequently we give an individual his or her first job and just as frequently we are one of only a few service industry employers who will do so. In addition to teaching our new employees the skills necessary for the particular job, we must train them about general job skills such as punctuality, attendance, task completion and the like. Conducting this informal training requires extra management supervision as well as accepting lower productivity from the new employee. When our industry's high turnover rate for hourly employees is factored in, it becomes clear that there is permanent lower productivity for many, if not most, of our hourly positions. This results in lower wages and initial compensation at or near the minimum wage in many parts of the country. It also results in a more restrictive benefits package, including restrictions in the provision of healthcare benefits. This is particularly true for part-time employees.

Because of its position in the service sector and as an engine of job creation, the membership of AH&MA has concerns about healthcare. These concerns operate on two levels. On the first, broader level, we agree that there are problems with our nation's healthcare system that need to be addressed. We believe that issues that need to be addressed by the Congress include:

- market-based methods to control excessive and growing cost of healthcare which typically exceeds inflation;
- universal access to healthcare for citizens and legal residents without limitation due to pre-existing conditions, change in employment or similar occurrence;
- allowing small businesses to join together for better buying power of insurance coverage;
- administrative reforms to reduce the costly burden of excessive paperwork; and
- legal reforms to combat fraud and reduce the costs of defensive medicine.

There seems to be little disagreement that all of the above reforms need to be done and, in fact, either as a freestanding bill or as part of more comprehensive attempts to reform healthcare, virtually all healthcare bills in Congress address these topics. However, there seems to be little else in any of these healthcare bills that is supported by a majority or even close to a majority of the House of Representatives or the Senate. While forces are fighting for agreement on approaches ranging from single payer to various versions of managed competition, these basic areas of agreement lie waiting for enactment. With so much at risk and so many wise people of good will from all parts of the political spectrum in disagreement about the more controversial and questionable areas of reform, we strongly urge this Committee to

move forward on those areas of reform on which there is a broad consensus, while continuing its work to reach agreement on other areas of healthcare reform.

On the second and narrower level of our concern, we view with distinct alarm the goal of the Administration's healthcare reform package to force all employers to provide insurance to all employees and pay 80 percent of its cost. The American economy is as diverse as it is broad and this "one-size-fits-all" approach to healthcare coverage will reward one segment of our economy while punishing another. This employer mandate simply can not be applied to the lodging industry without causing substantial disruption in our operations and job creation ability. In fact, employer mandates will force substantial job reductions in our industry.

As we said earlier in this testimony, we are one of the few industries that has a strong record of job creation for first time employees. We have found it disheartening and frustrating to find our jobs disparaged by the Administration in favor of high tech, high wage jobs in fast growing industries. All of us may wish that every American could qualify for a high tech job, but the truth is all of us can't. The fact that the economic value of jobs differ and the salary and benefits attributed to jobs also differ should not be used to disparage our first time employees or those of any other segment of the service industry. Honest labor in any industry should be respected as should the people who hold these jobs, and Congress should avoid creating economic disincentives that will shrink employment opportunities.

Unfortunately this seems not to be the case. When we argue that our industry's response to burdensome governmental action which increases the cost of labor far beyond its economic value will be a forced reduction in jobs, or a limitation on our job creating ability, this fact is typically ignored by many in the Congress and Administration. Even worse, this result is occasionally viewed somewhat favorably because the jobs we create are looked upon with disdain.

Recently a survey of our industry examining the nature and extent of healthcare coverage was conducted. Over 4,000 properties participated in providing information. The results were tabulated by Smith Travel Research, a respected information source in the travel and tourism industry. The information showed that there is a significant number of smaller properties unable to provide healthcare coverage in our industry. As stated above, there are a number of constraints and financial pressures on these properties which make the provision of health insurance impossible. We should note, by comparison, that virtually every company in our industry large enough to do so offers and shares the cost of healthcare benefits for its full-time employees, although the nature and extent of this coverage varies greatly in our industry.

Of interest is the fact that when the opportunity is presented, many employees do not choose to take health coverage. This occurs for a combination of reasons including personal coverage from another job, spousal or dependent coverage, or the need to maximize earnings. Whatever the reason, many employees with access to health insurance in our industry have chosen not to have coverage. We have always respected that choice and not forced an employee to take healthcare coverage. In that we believe our industry is not unique; we know of no industry which forces healthcare coverage on its employees. However, well over one-third of our smaller properties are unable to provide healthcare coverage and will be impacted most negatively by an employer mandate.

As debate over healthcare has progressed, it has become an accepted fact that where a company has a workforce which is near or at the minimum wage, that company will bear the full brunt of an employer mandate-there is no possible passing on of costs to employees through wage restrictions over time. For those employers, choices are limited. The obvious choice, to raise prices, does not exist for.many of our smaller operators due to the competitive environment they find themselves in. Of the choices left, some will go out of business, ceding their market share to large hotel properties in the area; most will limit job growth or eliminate jobs. Accurate predictions of job losses are difficult to make, but Smith Travel Research anticipates that 50,000 to 100,000 jobs may be lost due to employer mandates. This will not be spread uniformly across our industry but will be concentrated in the smaller property segment. The result for these properties will be just the reverse of that expected by the Administration. These employers will not be providing insurance to all their current employees. Instead they will be eliminating jobs.

What makes this outcome even more regrettable is that the Administration is now addressing the welfare problem, and one of its expectations is that the private sector can employ many of those currently on welfare. Our industry is undoubtedly one of those that the Administration will look to to increase hiring. Unfortunately, they will be somewhat late, since healthcare will have foreclosed a large part of our short-run job creating ability. We can not ignore the current reality that jobs and job opportunities will be foreclosed if an employer mandate is imposed.

We call upon this Committee to continue its efforts to find workable solutions to our nation's healthcare problems and to abandon, as a funding mechanism, the employer mandate.

STATEMENT OF THE JACKSON HOLE GROUP

The managed competition proposals presented by the Jackson Hole Group in September 1991 have contributed significantly to the current debate on American health care reform. Critical elements of our earlier work—purchasing cooperatives, accountable health plans, outcomes information—are instrumental to most current state initiatives and many proposals for national legislation.

While these ideas have formed the basis of mainstream thinking about health care delivery, Congress and the President have not yet been able to formulate a consensus strategy for ensuring universal coverage and effective cost containment. Each proposal for federal legislation seems stymied by its inability to predict the economic consequences of its implementation.

Changes of the magnitude envisaged under leading reform proposals have never been tried before, creating tremendous uncertainty that threatens to undermine reform. No one can confidently estimate the costs associated with various proposals, bow effectively different mandates will achieve universal coverage, the results of price controls or global budgets and whether they can be enforced, the lack of capacity that may result from a continued shortage of primary care practitioners or delays in accountable health plan (AHP) formation, how employers will use savings, the effects of increased consumer involvement in the decisionmaking processes, or the magnitude of savings that may be achieved by reducing the amount of ineffective care.

This level of uncertainty poses a serious risk to implementing effective reform. That risk, along with other lessons learned in actually applying managed competition, has caused us to revise selected parts of the original managed competition proposals. The underlying premise of Managed Competition II is that reform should adapt to observations and experience. This is exemplified by a commonsense approach in which government health care financing is always in balance, and is coupled to a step-by-step approach to reaching universal coverage. The original managed competition proposals continue to provide the basic framework for health care reform, as summed in Table 1.

Managed Competition II presents three technical improvements to the managed competition model, including refinements in the design of Health Plan Stores (HelPS), increased protection for consumer choice of provider, and incentives for cost consciousness and healthy behavior. It also adds two critical policy initiatives to the original model: a balanced health security budget and a universal coverage program.

ACCOUNTABLE HEALTH PLANS (AHPs) - "The Providers"

AHPs are the "engines of reform" and would shift the emphasis in health care from disease and intervention to prevention and wellness. AHPs are organizations that:

- Both finance and deliver the full range of a nationally defined package of health benefits.
- Are accountable to the public for satisfaction of their members and the effect of their services on members' health.
- Comply with established solvency and underwriting standards, including community rating and guaranteed issue and renewal provisions.
- Adhere to uniform data reporting requirements as established by a Health Security Commission.

SPONSORS - "The Health Plan Store"

Large employers, government, and Health Plan Store (HelPS - formerly known as HPPCs, Health Alliances) would all act as sponsors that facilitate individual choice of health plan. In general the role of the sponsor is to:

- Provide information and incentives for individuals to choose among competing AHPs.
- Pool risk and achieve economies of scale in purchasing.
- Set rules to assure equitable coverage of all members of the sponsored group.

STANDARD BENEFITS - "The Measure of Universal Coverage"

A standard benefit package would:

- Provide a basis for defining services to be made universally available to all Americans, and put private and government programs on the same footing.
- Facilitate side-by-side comparison of AHPs (increasing elasticity of demand), and promote efficiency through standardized claim forms and issuing requirements.
- Be continuously amended by the HSC and approved by Congress through a process insulated from inordinate political interference.
- Be based on scientific documentation of efficacy, including cost-effectiveness.

THE HEALTH SECURITY COMMISSION (HSC) - "The Referee"

The HSC would be an independent federal agency to guide, oversee, and facilitate a transition to a new health system. HSC powers and responsibility would be explicitly limited in legislation to:

- Recommending a standard benefits package to Congress.
- Recommending measures to balance the health security budget (see below).
- Coordinating a standardized data reporting system.
- Setting standards for and licensing AHPs and HelPS.
- Disseminating information and making recommendations on risk adjustment.
- Entering into agreements with state governments to administer appropriate regulations.

Table 1: Core Elements of Managed Competition that Remain Unchanged

REFINEMENTS OF THE MANAGED COMPETITION MODEL

MORE AND SMALLER HEALTH STORES (HELPS)

As introduced in the original managed competition proposals, HelPS in a reformed system would act as sponsors for individuals and small employers, giving them the ability to pool risk, achieve economies of scale, and drive the competitive process through informed individual choice. HelPS should not be regulatory or price setting agencies and should not negotiate, or limit choice of AHPs. Rather they would offer an informed set of choices to help individuals to weigh personal priorities in health plan selection. If HelPS were allowed to negotiate (i.e., refuse to offer plans whose prices are too high), individual choice would be limited. In addition, an effectively functioning and competitive market would be undermined by concentrating too much purchasing power in a single entity.

While many private sector initiatives are proving effective in holding down health costs, especially purchasing efforts of large employers, the problems associated with the small group and individual markets have not improved id the need for HelPS remains. We initially proposed creation of a single exclusive HelPS in each geographic area to address the needs of the small group market. Recently, however, we have seen that concentration of purchasing power in monopoly HelPS provides a structural device that can be easily applied to constrain—rather than support—competitive markets.

We now propose a system of competing Health Plan Stores. States would be required to create a state sponsored Health Plan Store for pooling consumer purchasing power, but multiple stores could be created to compete, providing that each meets the standards outlined below.

We appreciate the value of HelPS where participation would be voluntary, and have considered greater reliance on such structures. Experience has shown, however, that the small group market is easily fragmented into small, expensive groups that insurers avoid and small low cost groups that are easily insured. Such risk selection, and the associated cost shifts, remains the central problem which purchasing pools are intended to overcome id which will not be addressed by voluntary HelPS.

It therefore seems prudent to start with a system in which HelPS are the mandatory sponsors for the small group and individual markets, in that preferential tax treatment of health expenditures would be conditional on purchase of coverage through a licensed HelPS. This competing HelPS structure would still require special measures to ensure that the market is not undermined by adverse risk selection. Private sector organizations or associations could become licensed as HelPS if they agreed to open enroll, offer all AHPs, cover entire HelPS regions, meet solvency standards, id conform to other HelPS standards including a prohibition against conflict of interest. AHPs would offer the same base community rate to all HelPS serving designated regions. HelPS would compete only on their administrative overhead (the cost of which would be added to premiums) id their customer service. Competing HelPS that negotiate premiums would undermine community rating in the small group market. In a system of competing HelPS, states would have to take on the additional responsibilities of dividing their territory into HelPS regions, and coordinating risk adjustment and standardized data collection. With this design, competing HelPS can still achieve the original HelPS goals, yet satisfy those that contend a need for significant reform of the small group and individual markets exists.

REWARDS FOR COST CONSCIOUS CONSUMERS

Recent purchaser initiatives and state reforms have recognized the central role of consumer behavior (demand) in shaping successful reform. Any successful reform must include mechanisms for encouraging cost-sensitive utilization of health care services and healthy life style. A limit on the tax deductibility of health benefits remains the best way to instill cost-consciousness in health plan selection, control government expenditures, and raise revenue for low-income subsidies without increasing marginal tax rates. A revised tax code that addresses the concerns of the public while preserving cost conscious incentives would include:

- Extending full preferential health tax treatment to all consumers that purchase coverage through the appropriate sponsor (i.e., large employer or Health Plan Store). A requirement to use the appropriate group sponsor would ensure that the risk of costly illness is fairly spread.
- Capping tax deductions and exclusions at the average of competitive AHP prices in the lowest quartile (25%) of AHP prices in an area (instead of at the level of the low-cost AHP). Consumers would be free to spend additional after-tax dollars on health care.

- Allowing those who choose an AHP priced below the tax cap to keep the difference in a tax-flee health bonus account to be used to defray the costs of copayments, deductibles, and benefits not included in the standard benefits package or to supplement an individual retirement account.
- Allowing health plans to reward healthy lifestyles and behaviors with contributions to members' health bonus accounts.

ASSURING CHOICE PROVIDERS

The original managed competition proposals did not limit the type of health care delivery organizations that would compete in a reformed market. While we continue to support a marketplace which offers a wide variety of insurance and delivery models, we acknowledge public concern that consumer choice should not be restricted. For this reason, every sponsor should be required to offer at least one AHP with an out-of-plan (e.g., point-of-service) option, which allows enrollees to use non-AHP providers at increased cost. In the event that no AHP within a sponsor's region offers an out-of-plan option, all AHPs in that region would be required to do so.

UNIVERSAL COVERAGE UNDER MANAGED COMPETITION

BALANCED HEALTH SECURITY BUDGET

The original managed competition proposals focused on structural reforms and did not propose any specific strategy for financing universal coverage. However, as various financing schemes have been proposed in legislation, it has become clear that the financing of health reform has implications for how structural aspects will interact. A managed competition approach to structural reform requires a managed competition approach to financing.

The United States needs to achieve a predictable id acceptable level of health care spending. In the current environment, spending can not be allowed to exceed available funding. A balanced health security budget would instill fiscal discipline into the health care system by guaranteeing that federal health expenditures do not grow faster than revenue and promoting an honest and explicit debate regarding these expenditures.

The balanced health security budget can be regarded as a ledger that (1) continuously matches federal revenues to expenses, (2) relates the benefits package to available financial resources, and (3) relates the benefits package to providers' demonstrated ability to improve function and well-being. Federal health spending covered by the balanced health security budget would include low income subsidies referred to as EquiP 1 and 2 (see below), Medicare, and the Federal Employee Health Benefits Program (FEHBP). The increases in lost tax revenue (tax expenditures) to the federal government, due to the preferential tax treatment of health expenditures, would also be counted as part of the balanced health security budget, thus helping to contain the growth in mandated private health security costs.

Under such a system, government health expenditures would be disbursed on a pay-as-you-go basis, and the health system would move toward universal coverage in carefully monitored stages. Each year, Congress and the HSC would adjust three elements of the health care Financing system in order to achieve an annual health budget target. If projected expenditures exceed the rate of increase in the health budget target, the HSC would recommend to Congress either (1) an adjustment to the benefits package (the benefits package would be voted on in a manner similar to the military base closing procedure), or (2) a slowdown of the expansion in low-income subsidies. If Congress opted to not accept these recommendations, it would have to appropriate more money to achieve fiscal balance. While it might be preferable to have an explicitly earmarked health tax as the funding source for the balanced health security budget, it may be best to begin with existing sources of public health care funding. Ultimately, Congress must know what it is spending, who is covered for which services and the impact of benefits on the health of Americans.

UNIVERSAL ACCESS AS A FIRST STEP TO UNIVERSAL COVERAGE

The best way to achieve universal coverage is through a competitive, premium-based system with adequate public subsidies for low income consumers, financed through progressive taxes. Such a system will require several years to be fully implemented id effective. Providers will need time to build high quality health plans, the government will need time to measure and evaluate progress and accumulate real savings to public programs from managed competition, and individuals will need time to understand and avail themselves of the reformed system. If we wish to build a national system that is sustainable, affordable, and integrated, then we

must introduce significant policy elements carefully, in a way which permits us to fully understand their effects.

We must first establish a system in which all individuals have access to affordable coverage-universal access-as a first step towards universal coverage. Such a system would help those who need it most (i.e., the poorest individuals through subsidies and individuals and small employers through purchasing cooperatives and insurance reform), allow establishment of a truly competitive system, and permit a smooth transition to universal coverage by, say, 2002 if Congress passes comprehensive health reform in 1994.

Achieving universal coverage in a fiscally realistic manner will require that public programs are incorporated into a managed competition system and that a true universal access system is in place. A staging process follows:

STAGE 1—Equity Program, Part 1 (EquiP 1): A government subsidy program for the current categorically needy (those receiving AFDC and SSI benefits) acute care portion of the Medicaid program that "equips" them to obtain coverage.

Perhaps the greatest and most consistent challenge faced by state governments in recent years has been the dramatic increase in and unpredictability of costs in their Medicaid programs. While more states, like the private sector, now look to managed care as a means of tackling cost and quality problems, like more than 10% of Medicaid beneficiaries are in true managed care programs like HMOs. Reform must accelerate this process to instill financial discipline and to realize predictability of costs and accountability for quality where neither have existed for some time. Furthermore, EquiP beneficiaries should have access to the same AHPs and standard benefits as the general population to eliminate inequities in the health care system. States would be responsible for the administration of their respective EquiP 1 programs, which would be fully funded as of the first year of reform and designed as follows:

- Because together they are generally regarded as above average risk and should be explicitly financed to ensure their costs are spread equally, the AFDC and SSI population would be maintained, at least initially, as a separate risk pool that is covered by AHPs.
- Each state, or contracted sponsor acting on behalf of the state, would base capitation rates for the EquiP 1 population on actuarially sound estimates of the average reasonable costs across AHPs of delivering a standard benefit package adjusted to the special needs of the AFDC and SSI population.
- The federal and state governments would jointly contribute 100% of the price of benefits for EquiP 1 beneficiaries. States would be required to maintain their current level of financial commitment to acute Medicaid and uncompensated care (current expenditures would be trended forward according to EquiP 1 experience). Thus, they would be at a relatively greater risk for their AFDC and SSI populations.
- Using a one-year voucher, the EquiP 1 eligible population could choose from among participating plans through their own EquiP 1 HelPS during the annual open enrollment period. For individuals who fail to select a health plan, the EquiP 1 HelPS would choose one for them.
- Once the EquiP 1 population had experience in AHPs and its risk could be predicted and adjusted with relative accuracy, it would be served by the local community HelPS, where the government would pay a competitive health status adjusted community rate on their behalf. Additional benefits that were not part of the initial standard benefits package available to the general population would be added as needed, funded jointly by states and the federal government and provided by AHPs.
- While personal costs for EquiP 1 beneficiaries should be mitigated so coverage is within their reach, they, like everyone else, should pay some portion of the cost of their care to instill a degree of cost-consciousness.

STAGE 2—Equity Program, Part 2 (EquiP 2): A government subsidy program for individuals below 200% of poverty, and those ineligible for EquiP 1 that "equips" them to obtain coverage.

The below-poverty uninsured population consist of 10.8 million individuals (28.1% of the unisured), while the 100%–200 % of poverty population represents an additional 12.5 million individuals (32.5% of the uninsured).* In addition to the subsidy available to everyone through the tax treatment of benefits and the contribution to health insurance by some employers, this population needs further subsidies to have meaningful access to the health system. EquiP 2 eligible individuals would receive

* EBRI Analysis of the March 1993 Current Population Survey.

subsidies in the form of vouchers, and would select their coverage through their local HelPS or large employer, depending upon employment status, thus minimizing the government's role in the program. EquiP 2 funding would be phased in as funds accrue to the government. The initial subsidization targets would be full subsidization into the low-cost plan for EquiP 2 eligible individuals below 100% of poverty, and a sliding scale of subsidies for beneficiaries between 100% and 200% of poverty.

Congress should appropriate sufficient funds to subsidize everyone in EquiP 2 by the year 2002. If these subsidies are effective, at least 95% of this population should be covered by then. If 95% of this population is not covered, Congress would need to expand the EquiP 2 subsidy program or proceed with some form of coverage mandate.

The present Medicaid program creates substantial disincentives for returning to work, since beneficiaries lose coverage after they cross the eligibility threshold. Combined with the loss of other low-income benefits such as the earned income tax credit, food stamps, and housing subsidies, this threshold represents a significant disincentive to earn more. While any scaling of health care subsidies would be an improvement over the current system, the pressing need to tackle welfare reform in conjunction with, or soon after health care reform, is apparent. To increase incentives for work, the increase in cost of health insurance associated with moving to a higher income bracket should be minimized. This can best be assured by phasing out public assistance for EquiP 2, at a gradual rate as income increases, and may require expansion of EquiP 2 beyond 200% of poverty.

STAGE 3—Guaranteeing Sustainable Universal Health Care Coverage

No system which provides for responsible financing can guarantee identical coverage for every U.S. resident. Just as definitions of "full employment" accommodate known structural deficiencies of the employment market, any working definition of "universal coverage" should allow for known political constraints (e.g., resistance to mandates) as well as unknown behavioral responses to reform (e.g., possible reluctance of wealthy to purchase insurance). Universal coverage might be defined as the point at which it can be verified that, say, 95% of the population are covered. (We are currently conducting some analysis that may allow us to be more precise in defining universal coverage.) As reform proceeds, the target percentage could be adjusted to reflect the point at which the additional cost of bringing individuals into the health security system through government means, such as a mandate or increased outreach, is too great for the public to accept. At some point it may make sense to adopt a policy that uniquely targets care for the residual percentage of uninsured, rather than devoting limited resources to the difficult and expensive task of pulling every individual into the general system of universal coverage.

To ensure that universal coverage is achieved within a reasonable timeframe, legislation should include a mandate (compulsory coverage) for the year 2002. If universal coverage, as defined by Congress, has not been achieved by 2002, this measure would automatically force Congress to implement a mandate unless it took proactive measures to attain universal coverage by other means, such as increasing the scope of the Equity Program.

Congress should defer a decision on the nature of the mandate until 2002 to ensure that it is the appropriate measure. By then, much will have been gained from experience with a reformed system; broad low-income subsidies would be at or near full phase-in; competing AHPs would be functioning; group purchasing and health insurance reforms would have been in place for some time; and the residual uninsured population would likely be less significant in number and different in character than the presently uninsured population. Only with accurate information regarding the number and percentage of uninsured by employment status, income and demographic groups, geographic location, and health status can an informed decision be made regarding what type of compulsion, if necessary, would best lead to universal coverage. For example, if it is primarily low-income, unemployed individuals that remain uninsured it is unlikely that any form of mandate would be effective; instead, changes to the EquiP program would be required. On the other hand, if mostly wealthy, non-working individuals were uninsured, a free-rider tax would probably be the most effective way to achieve universal coverage. Finally, if large numbers of employed individuals were uninsured, an employer mandate might be the most appropriate. (Mandates are discussed further in the Appendix.)

MEDICARE

Medicare recipients should have the opportunity to receive the same universal standard benefits as the general population, with the same choice of providers and health plans. Equally, beneficiaries should be motivated to save money and pursue prevention and health maintenance measures. While reform of Medicare cannot be

immediate since many beneficiaries value the present program, Medicare should ultimately resemble the rest of the health care system. The standard benefits package will be more comprehensive than current Medicare benefits and potentially eliminate the need for Medigap policies. While AHPs should be paid on a capitated basis for providing this enhanced benefits package to Medicare beneficiaries, cost-cutting measures proposed by Congress and implemented by HCFA could continue to control traditional Medicare expenditures. Medicare would start to be integrated into a managed competition environment as follows:

- The Medicare population would be maintained as a separate higher risk and cost group. During an annual open enrollment period, regional Medicare HelPS would allow current Medicare beneficiaries to choose between traditional HCFA-administered Medicare with the present Medicare benefits, and competing AHPs offering the more comprehensive standard package, including prescription drugs. Beneficiaries would have a greater choice of AHPs than present law permits, including AHPs that offer an out-of-plan provider option.
- For beneficiaries who choose an AHP, the federal government would make a defined contribution toward premiums. Under present law, Medicare risk-contracting HMOs are paid 95% of what HCFA estimates it would have paid for Medicare covered services had beneficiaries remained in the fee-for-service sector. This system is fraught with problems, including ties to fee-for-service medicine and the geographic inequities in the distribution of Medicare reimbursement that penalizes regions of the country where health care expenditures are lower and better managed. Whatever future payment methodology is used, it should allow for a transition toward a system in which Medicare reimbursement is determined by competitive bidding and consumer cost sensitivity (as in the private sector), and low cost regions are rewarded for their effectiveness. One such system would tie the government contribution to: the average of competitive AHP bids in the lowest quartile of AHP prices in a Medicare HelPS region, or the adjusted average per capita cost (AAPCC), whichever is lowest. Once the penetration of AHPs into the Medicare market exceeded a certain percentage, say, 50%, the tie to the AAPCC would be removed.
- Beneficiaries who choose an AHP would be responsible for paying the difference between the government contribution and the premium cost of their plan of choice. Present employer-sponsored retiree health benefits that pay for wraparound coverage could be redirected to defray the difference between the government's defined contribution and an AHP's premium. Also, employers and retirees might agree to reconfigure retiree health benefits into a defined contribution, added to the government contribution, so that those who join AHPs receive the savings derived from their purchasing decisions.
- Beneficiaries that age into the Medicare program would be encouraged to continue obtaining standard coverage from AHPs.
- Eligible low income Medicare beneficiaries would continue to receive premium and cost-sharing assistance through EquiP 1 or 2.
- The present policies that impede HMOs from participation in the Medicare risk contracting program would be aggressively reduced with a significant shift toward policies that develop Medicare-oriented AHPs and encourage them to compete to serve beneficiaries.

As AHPs find ways to improve efficiency, they should be able to offer rates that are at or below the contribution set by government, even though they offer a richer standard benefits package. The opportunity to obtain more benefits at no additional, or only slightly higher cost, as well as continuity of care through primary care physicians, reduced paperwork, and the elimination of the need to purchase a Medigap policy, should motivate Medicare beneficiaries to join AHPs. However, present Medicare beneficiaries who place more value on the fee-for-service alternative could retain the opportunity to stay in the current system.

As AHPs succeed in lowering their costs below fee-for-service Medicare program costs, and more Medicare beneficiaries choose to enroll in AHPs, the federal government would achieve significant savings.

CONCLUSION

We can only achieve the required broad-based support for health care reform if we avoid rash, complex, and untested strategies. Federal reform measures must be sufficiently flexible to adapt to whatever new behaviors emerge in response to the changed health care environment. They must not preempt our ability to adjust key elements of the financing system as we learn more about what works. It would be foolhardy to guarantee universal delivery of a rich package of benefits only to find

ourselves bankrupt before the decade expires, thereby undermining every American's ability to receive needed health care.

Managed Competition II is offered as a pragmatic approach to achieving universal coverage. If its concepts are ultimately selected as a template for reform, then several key elements of MC II are necessary if the integrity and effectiveness of the proposal are to be preserved:

(1) Staging of health care reform with the attainment of universal coverage by a specific date that allows a sufficient time interval for the development of a lasting health care system.

(2) Establishment of a health system based on consumers choosing between accountable health plans which compete on both price and quality.

(3) Promotion of cost, quality and health-conscious decisions by consumers.

(4) Obligatory purchasing of health plans through group sponsors including Health Plan Stores and large employers.

(5) A public program of equitable health care with the same incentives and benefit choices as the private sector.

(6) A balanced health security budget with pay-as-you-go financing of public health expenditures that prevents unfunded health care entitlements and instills fiscal responsibility.

It is our desire that Managed Competition II will expose to public and political Scrutiny the interplay between funding, benefit levels, and health care effectiveness. It is designed to expedite access to affordable insurance coverage to every American, and provide a mechanism for sustaining universal coverage far into the future, regardless of shifts in the political mood, advances in technology, or changes in public needs. National health care reform can not hope to fix on a perfect financing formula in 1994; it must put in place, instead, prudent mechanisms for experimenting with, learning from, and responsibly managing our health care economy for the long term.

Appendix: Discussion of Mandates

Combination of Mandates

A combination of employer and individual mandates, as outlined in Table A–1, best builds on the current employment-based system, ensuring that the 99% of companies above the 100-person threshold currently offering coverage to their employees would continue to do so.

Employer Mandate for Large Employers

- All employers with more than 100 employees would have to offer a choice of AHPs offering the standard health benefits package to employees who work more than 30 hours per week, and their dependents. Employers would be required to make a defined contribution of a minimum of, say 50% of the price of the low cost plan to the health care premiums of their employees. To minimize employment effects, the mandated contribution requirement would be phased in over a period of time. A prorated contribution would be required for part-time workers who worked more than 1,000 hours per year and a payroll tax of X% would be paid for workers who work 1,000 hours or less.

- To assuage effects on employers near the HelPS threshold size, there would be a gradation of their financial obligation in accordance with firm size. These employers would not be relieved of their obligation to offer standard health care benefits.

Individual Mandate for Individuals and Small Employers

- Part-time workers (not otherwise covered) working 1,000 hours or less per annum for an employer with more than 100 employees and all individuals (not otherwise covered) not employed or those employed by firms with less than 100 employees would be obliged to purchase coverage through their local HelPS.

- At the direction of their employees, small employers would be required to make a monthly payroll deduction and send the amount to the appropriate HelPS.

Table A-1: Description of Combination of Mandates

To the extent that large businesses compete with small businesses in the same industry, employee packages would differ, but since a mandate would exist in both sectors, total compensation in any individual firm should not be different. However, if employees do not recognize the trade-off between wages and benefits, small employers would have a hiring advantage. A combination of employer and individual mandates would increase the incentives for firms to game the threshold by engaging in such actions as hiring temporary personnel and splitting companies into separate entities. However, this may be mitigated by phasing in the percentage requirement with firm size.

Low income is the major determinant in access to health insurance, not size of firm in which one is employed. Therefore, for a combination approach to be equitable and efficient, the subsidization formula used must be consistent across mandate environments, and tied to income level (as in the EquiP program), not employment status. Individuals eligible for EquiP subsidization would use their vouchers either through their large employer or the HelPS to defray the cost of coverage. If, on the other hand, subsidies under the employer mandate were targeted at employers, as opposed to individuals, the employer mandate portion of the combined mandate would represent an inequitable and inefficient financing mechanism, and would result in the reallocation of labor on the basis of the subsidies available (so-called *sorting).*

The most expedient, efficient, and politically viable way to enforce the individual portion of the mandate would be through a free-rider tax. Individuals choosing not to purchase coverage would be required to pay a tax. Advantages of a free-rider tax are that it could be progressive and enforced by the IRS. The free-rider tax would be equal to a fixed amount plus a penalty that would be directly proportional to income. While such an enforcement strategy would not perfectly attain universal coverage, it would go a long way towards ending the free-rider problem while minimizing societal and economic dislocation.

Some proposals have embraced employer mandates and subsidies targeted at firms because they allow the government to shift some of the burden of public programs onto employers and create the perception that no one is paying the price.

While fiscally attractive to the government, this type of mandate perpetuates cost-shifting, and causes the most economic dislocation because it effectively raises the minimum wage in many firms. To the extent that employers were unable to take the additional costs of health premiums out of wages, an employer mandate would cause some unemployment, especially in firms not currently offering coverage and in firms with low wage workers.

INDIVIDUAL MANDATE

If individuals are targeted to receive low income subsidies to make those subsidies more explicit, efficient, and equitable, a mandate targeted at individuals makes sense as well (see Table A–2). An individual mandate could be easily and quickly implemented without disrupting present purchasing arrangements. It would satisfy those who believe the ultimate obligation to purchase health care should be on the individual, not the employer, and that health care coverage should be divorced from employment status.

- All individuals would be required to purchase coverage as of the date of implementation, or pay a free-rider tax.
- All employers, while not required to finance coverage, would be required to offer coverage, either through the HelPS if they have fewer than 100 employees, or directly for large employers.
- Voucher eligibility and preferential tax treatment would be contingent upon purchasing coverage through the appropriate sponsor.

Table A-2: Description of Individual Mandate

The greatest potential disadvantage of an individual mandate is the risk that companies that are currently active, value-based health purchasers will cease these activities, and will perform the minimum duties necessary to fulfill the obligation to offer coverage. It is not possible to predict the extent of this behavior. However, business leaders suggest that competitive forces in the labor market may be sufficiently strong to maintain an active employer role, especially if there is a stipulation that predicates tax-preferred treatment of health expenditures on purchasing through the appropriate sponsor (the large employer for its employees). In addition, in a mandated environment, employees will value health purchasing that maximizes the wage portion of their compensation and secures quality health care. Employees of large firms without access to HelPS will look to their employers for purchasing expertise, since most employers purchase coverage for employees today If large employers prove to be inefficient purchasers, it would be possible for employees to pressure their employers to go to secondary purchasers such as purchasing coalitions, to purchase coverage.

Another potential serious disadvantage of an individual mandate is that upon passage, all individuals might demand access to HelPS. It is unlikely that Congress would have the political will to deny this. If the public then demanded that HelPS exercise greater control over the cost of health care, the result could be slow, but steady progression toward covering a great majority of the population through the HelPS-leading to regulation and possibly a single payer system. To some extent, competing HelPS should mitigate this danger.

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